

CARROLL THE VALUE OF STREET RETER WELTHAMSELMEN TO ME KNOWE IN ESTAINANTEN AL MENDOWNEW BUREING HOME ROUTE - E MARY MERCENTSANKERE INDUST & TO LENDRE WHILE THE SAMPIETE SAMPIETE OF THE STANDAR House with SAMBEL HANN SARAB CATHERINE MIER 113-04-34公人的一部。自治社会是自治院的 THE SECOND SENSIFICATE (TENHARL) & HELE ARTERSLLEROTA CARDIDLASCULAR NS 47 FEAR Transit Myresever west 1888 Fill Rene server staylor St. watts Jeneter, calleer with Carroll Co. wo. A car and particularly and the particular and a care of the particular and the particular

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	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
-	10289 CANADO CERTIFICATE OF DEATH 09382
1.	PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If Institution: Residence before admiss a. STATE MARYLAND b. COUNTY
/	the City OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMODIS 17
1	d. NAME OF MOSPITAL OR INSTITUTION HE not in hospitel pive street address) d. STREET ADDRESS ON A FAR YES NO.
3.	NAME OF DECEASED Sirst Suidle JOHN HARRISON 1. DATE OF DEATH SUIGHT 1967
	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. (SE (In years IF UNDER 1 YEAR IF UNDER 24 HR 18 18 18 19 18 18
do	c. USUAL OCCUPATION (Give kind of work production during most of working life, even if refired) CARPENTER 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & Stete, or foliagn country) CARPENTER 12. CITIZEN OF WHAT COUNT CONSTRUCTION SHAHOKIN PA. USA.
13.	FATHER'S NAME 14. MOTHER'S MAIDEN NAME WILLIAM BURGET ANNIE BURGET
(Y	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address NWL ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Address
	18. CAUSE OF DEATH Enter only one causa per line for (a), (b), end (c) to PART t. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) INTERVAL BETWEEN ONSET AND DEATH ONSET AND DEATH
	331 × DUE TO Conditions, if any, which (b) Cerebral auch 1966
	gave rise to immediate couse (a), stating the underlying couse last. (c)
CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOP PERFORMED YES NO
CERTIFI	208. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
MEDICAL	20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, ferm, p.m. 19 et work et work 19 et work
	21. I certify that (I) (this hospital) attended the deceased from Library, 1967 to Miller, 1967, that (I) (we) saw the deceased alive on 1967, and that death occurred at 1 3 m from the causes and on the date stated about
	22a. SIGNATURE ATTENDING MED. STAFF SIGN STAFF STAFF SIGN STAFF STA
	22c. PHYSICIAN'S NAME (Type) NASTIN 22d. ADDRESS ADDRE
23	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL (Specify) DULAWEY VALLEY MOM. COCKEYSVILLE MD.
24	FUNERAL DIRECTORY SIGNATURE JOHN 134MD Stro Moderns M. 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE DATE DATE 1250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE DATE DATE 1250. REC'D BY REGISTRAR'S SIGNATURE DATE DATE 1250. REC'D BY REGISTRAR'S SIGNATURE DATE DAT
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MAKTLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09383 CERTIFICATE OF DEATH 03383 requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Montgomery o. COUNTY o. STATE MARYLAND Maryland carban papers. Pages 1 vertex ithin 72 hours after Carroll filled in by the b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Silver Spring Tyrs.9mos.5dys Sykesville e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Springfield State Hospital 2905 Lindell St. NO X Middle 4. DATE Day 3. NAME OF First Year Last DECEASED 67 LUNDAY CARLTON JULY 19 CLARENCE 19 DEATH (Type or print) IF UNDER 1 YEAR | IF UNDER 24 HRS. 9. AGE (In years S SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED **NEVER MARRIED** attending physician and camperemary last birthday) Manths Days Haurs Male White -12-0h and in any WIDOWED DIVORCED 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of wark done 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of working life, even if retired) North Carolina II.S.A Carpenter 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME cremation, ar remaval, Martha (last name unk. William Carlton 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. permit. (Yes, no, ar unknawn) (If yes give war or dates af service) 579-09-4091 Records. Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit p burial, crematic ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Lobular pneumonia IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by Conditions, if any, which gave Heart failure Davs rise to immediate cause (a), DUE TO r this certificate has been si detached far use as the b te Dept, af Health priar to b stating the underlying cause Arteriosclerotic heart disease Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) Psychotic depressive reaction. CBS with alcohol intox., 19. WAS AUTOPSY PERFORMED? YES X NO ATTENDING PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II af item 1B.) 20o. ACCIDENT WAS UNDERLYING [detached from the Dept. af P OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or tawn) (County) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Haur o.m. While Nat While at wark at wark 21. I certify that (I) (this haspital) attended the deceased fram 10-13-59 M, fram causes and an the date stated above. 7-19-67 19 and that death accurred at saw the deceased alive an_ 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. X 7-19-67 M.D. DIRECTOR 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Sykesville, Maryland Octavio A. Ruiz. director, shauld be BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d) LOCATION (City or Town) (County) (State) REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09385 09385 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY 0) b. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) MARYLAND Maryland Carroll c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b del Westminster Westminster e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS form in pencil in Item 18. Give Pages 1, YES NO Rd. 4 Westminster Rd. 4 Westminster after death. the certificate, writing the ward "pending" in pencil in Item 18. Give Pag 4 shauld be farwarded to the Chief Medical Examiner's Office alang-with 3. NAME OF 4 DATE Last Manth Doy Year DECEASED (Type or print) PAIT.A CHEVCHENKO DEATH July 29 IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 24 HRS B. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Days Haurs Nov. 6, 1938 WIDOWED DIVORCED This certificate shauld be executed within 24 haurs Female White 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY COUNTRY? haurs after Housewife At Home Romania II S A File pages 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Carl Gross Maria Velixer 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address event within 72 (Yes, no, ar unknawn) (If yes give war ar dates of service) Corleto Funeral Home, Wilmington, Delaware INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: ONSET AND DEATH burial-transit IMMEDIATE CAUSE (0) Multiple shotgun wounds DUE TO in any Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause 0 and 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) cremation, ar remaval, PERFORMED? please execute the certificate, NO be 20a. EXTERNAL CAUSE WAS PRIMARY X or CONTRIBUTING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 1B.) 3 shauld CAUSE OF DEATH Subject was shot with shotgun in 1t. side neck MEDICAL 20e. PLACE OF INJURY (Home, farm. 20f. (City or town) 20d. INJURY OCCURRED (County) (State) 20c. TIME OF INJURY Manth, Day, Year at wark Nat While factory, street, affice bldg., etc.) may be retained for your FUNERAL DIRECTOR: Page Westminster Carroll Md. Home 21. I certify that I took charge of the remains described above, held an Autapsy Inquiry 🗍 and in my apinian Inspection . death resulted from: Accident Natural couses Suicide Undetermined monner Hamicide | X CHIEF MEDICAL EXAMINER prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE

THEFOR Fisher NAME OF CEMETERY OR CREMATORY

Silver Brook

VR A15ME (5) 6M 1/67

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Health

EXAMINER'S

NAME (Type)

23o. BURIAL CREMATION.

24. FUNERAL DIRECTOR

REMOVAL (Specify) Burial

Mc Cully 130 E. Fort Ave

2

Wilmington, Delaware
GISTRAR 25b. REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR 1967 Munice

DEPUTY MEDICAL EXAMINER

DATE AUG

Address (Street, city, tawn, ar caunty)

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09386 09386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPI PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY a. STATE b COLINTY Page deloy is b. CITY OR TOWN (If autside carparate limits, write RURAL and give neorest town) MARYLAND Maryl and Carrol1 c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) pup PM3. Near New Windsor Union Bridge d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 4 should be farworded to the Chief Medical Exominer's Office olong with form in Item 18. Give Poges Horton's Boarding House NO X hours after death. NAME OF First DATE Day DECEASED CRUMBACKER (Type or print) GEORGE DEATH 1967 S. SEX 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Manths Jast birthday) Sother So WIDOWED DIVORCED White Male P 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY event within 72 hours ofter WORK WOOD 13 FATHER'S NAME be executed within in pencil STAUFFER 17. INFORMANT (Yes, na. ar unknown) (If yes give war ar dates of service) pending 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a). This certificate should please execute the certificate, writing the ward DUE TO in ony Conditions, if ony, which gave rise ta immediate cause (a). DUE TO stating the underlying cause puo be used PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY removol, PERFORMED? NO 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 3 should 0 PRIMARY ar CONTRIBUTING CAUSE OF DEATH cremation, 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) Nat While factory, street, affice blda., etc.) at wark 21. I certify that I took charge of the remains described above, held an Autopsy (**) Inspection Inquiry , fo FUNERAL DIRECTOR: and in my apinion the funerol director. death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner may be retained CHIEF MEDICAL EXAMINER prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER 7-5-67 **EXAMINER'S** Health RUSSELL S. FISHER, M.D. Address (Street, city, tawn, ar county) NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL CREMATION. DATE THEREOF (County) (State) 2 24. EUNERAL DIRECTOR VR A15ME (5) 6M 1/67

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W. PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 00388 funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) COUNTY b. COUNTY CARROLL 4 7 7 MARYLAND and b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporata limits, write RURAL and give nearest town) write RURAL and give nearest town) .⊆ d. NAME OF HOSPITAL OR INSTITUTION (it not in hospital, give street eddress) filled a. IS RESIDENCE ON A FARM? YES NO carbop papers. completely 3. NAME OF Middle DECEASED OF (Type or print) DEATH 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. and last birthday) Months WIDOWED DIVORCED T USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if retired) 16. SOCIAL SECURITY NO. | 17. INFORMANT Φ 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO gave rise to immediate cause DUE TO (a), stating tha underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)) 19. WAS AUTOPSY PERFORMED? Operation + beopen June 1947)
20a. ACCIDENT WAS UNDERLYING [| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Part II of item 18.) NO (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) factory, street, office bldg., etc. While Not While Hour a.m. at work at work to July 25, 18.7, that (1) (we) last 21. 1 certify that (1) (this hospital) attended the deceased from march, 5., 19..., saw the deceased alive on July 25 1947, and that death occured at 2 M, from the causes and on the date stated above. 22b. DATE 22a. SIGNATURE ATTENDING MED. SIGNED DIRECTOR death. Page roof of FUNERAL director, page 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION. 23d. LOCATION (City. (Stata) REMOVAL (Specify) Sign B 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 7/61

OF HEALTH

A Commence of the Commence of MERCHAN TERROLD LITERAND OF STREET SEE IN EST NOTE OF THE PARTY OF Penne Lange Com CHERRY AND RELIEVED TO SEE THE PROPERTY SERVICES. SERVICES Trade & Honesty 1 CARP DIFFICERL THE RESIDENCE OF THE PROPERTY a second without the second second and the second Comment of the second Control of the Contro and the second s F- 1- 139 7 2 July of the stay so of the standard mile

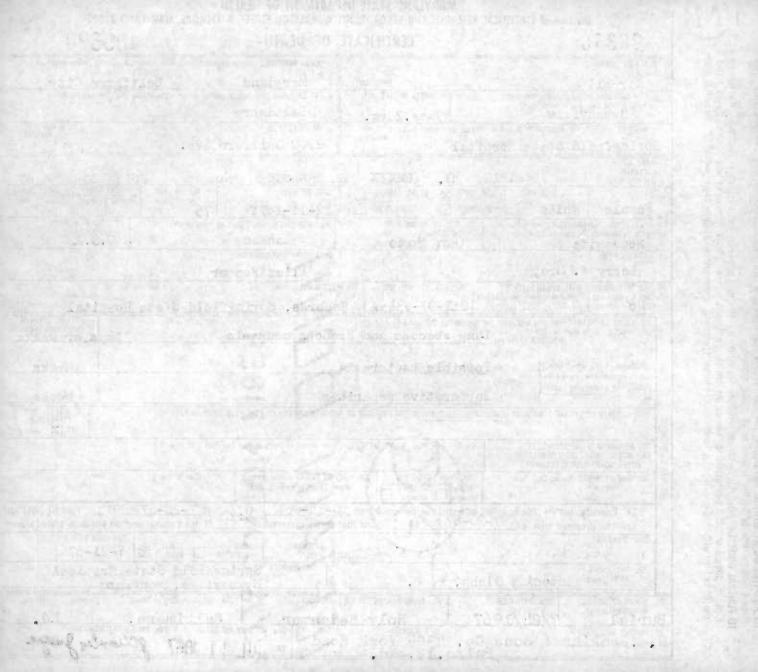
MARYLAND STATE DEPARTMENT OF HEALTH

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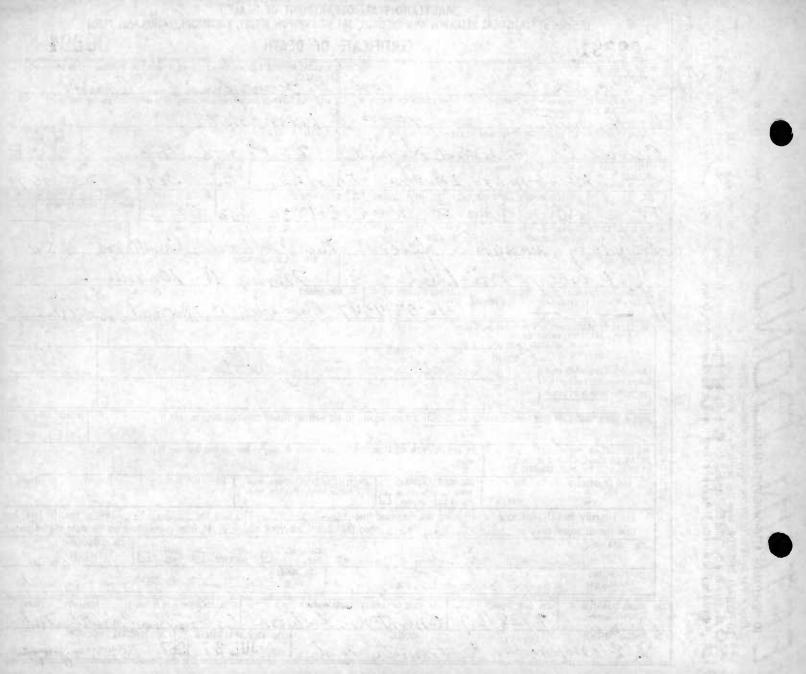
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09330 09390 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 haurs after death funeral 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH o. COUNTY Carroll b. COUNTY o. STATE Maryland cian and completely filled in by the fur lease remave carbart papers. Pages 1 and in any event, within 12 hours after o MARYLAND Baltimore City b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town)

Sykesville CLENGTH OF STAY IN 1h c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Baltimore 9mos.2dvs. e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) Springfield State Hospital 2900 Guilford Ave. NO X Middle NAME OF 4. DATE Year First please remave carban DECEASED MARIE XXXXXXX ELLERBROCK 20 JULY 19 67 (Type or print) DEATH IF UNDER I YEAR IF UNDER 24 HRS B. DATE OF BIRTH 9. AGE (In years SEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** last birthday) Manths Haurs White Female 12-11-1891 WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of warking life, even if retired)

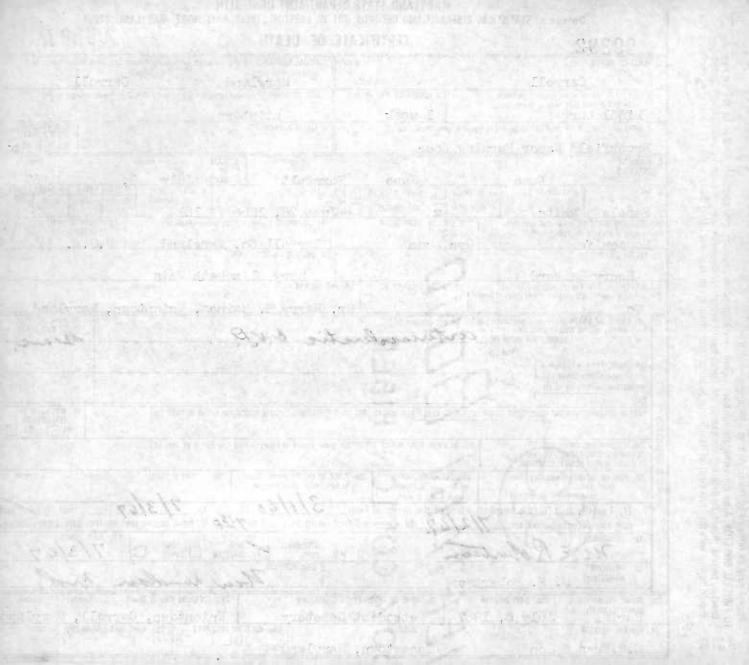
Housewife COUNTRY? **NDUSTRY** attending physician permit. Then please Kansas Own Home 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar remaval, Larry A. Grav Alice Foster WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war ar dotes af service) 212-07-9343A Records, Springfield State Hospital burial, crematian, 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN Days or weeks burial-transit Lung abscess and brenchopneumonia IMMEDIATE CAUSE (a) signed by Canditians, if any, which gove (b) Possible bacteremia Weeks rise ta immediate couse (a), DUE TO has been s ise as the t th priar tab stating the underlying couse Page 4 may be retained by the hospital ar attending (c) Suppurative nephritis Weeks last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES X NO this certificate for 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH shauld be detached with the State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) (State) 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, affice blda., etc.) Hour a.m. Nat While at wark at wark TO FUNERAL DIRECTOR: After 21. I certify that (t) (this haspital) attended the deceased fram 10-18-66 19___, that (1) (we) last M. fram causes and an the date stated above -20-67 , and that death accurred at saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE **ATTENDING** 7-21-67 director, page should be filed 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Antonius Glahn D. Sykesville, Maryland 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) 23g. BURIAL CREMATION. REMOVAL (Specify)
Burial Baltimore Holv Redeemer 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR W. Jenkins ADDRESS 05 York Road 2Sa. REC'D BY REGISTRAR & Sons Co VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) filled in by the funeral o. COUNTY? b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 corporate limits, write RURAL and give nearest town) write RURAL and give-nearest town d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) IS RESIDENCE ON A FARM? YES NO 3. NAME OF 4 DATE Month Lost Doy Year DECEASED 25 1967 AUENIA DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** remove last birthdoy) Months Hours WIDOWED DIVORCED 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? pleose INDUSTRY Secretary 13. FATHER'S NAME removal. en attending p AS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Same (Yes no, or unknown) (If yes give wor or dotes of service) INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) þ DUE TO signed 1 Paterischerotie Gest Disease buriol, Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been 0 the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use NO F for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) Hour o.m. Not While ot work ot work 21. I certify that (I) (this hospital) attended the deceased fram 1962, to 1967, that (1) (we) last be retained and that death occurred at 4-30 MM, from causes and an the date stated above. sow the deceased olive an 22b. DATE, SIGNED 220 SIGNATURE DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should k 23c. NAME OF CEMETERY OF CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION. 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) VR A15 (4 20 M 1/66



	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
	09392 CERTIFICATE OF DEATH 09392
r death.	1. PLACE OF DEATH o. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. STATE b. COUNTY Carroll Maryland Carroll
haurs after haurs	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Middleburg c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Uniontown
24 ho ed in pers.	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
y fille	3. NAME OF First Middle Lost 4. DATE Month Doy Year
ecuted wi	DECEASED (Type or print) S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED NE
te be extion and assertion and infantant	Female White WIDOWED JUNGKED June 28, 1866 101 Yrs. 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife UDOWED June 28, 1866 101 Yrs. 11. BIRTHPLACE (County & Stote, or foreign country) INDUSTRY COUNTRY? U.S. A.
certificat g physic Then ple moval, a	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
e death attendin ermit. In, ar ret	Henry Bankerd 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) No Mr. Harry H. Haines, Uniontown, Maryland
Page 4 may be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, ar removal, and in any event, within 72 hours after debth	18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last. (b) DUE TO (c)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the shauld be filed with the State Dept. of Health prior to	20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19 20d. INJURY OCCURRED While of work of twork of two twork of two twork of two
TTENDI rained b TOR: Aff hauld b th the Si	21. I certify that (I) (this haspital) attended the deceased from 3/1/40, 19, ta 3/67, 19, that (I) (we) la saw the deceased alive on 7/2/67 19, ond that death occurred at 7/50 M, fram couses and an the date stoted obove 220. SIGNATURE 22b. DATE SIGNED,
L OR A be ret of	M.D. ATTENDING MED. STAFF DIRECTOR PHYS. 7/3/47
SPITA 4 may ERAI Gr, Po	NAME (Type) M. E. Robertson How kindson, And,
Page No Fundirect shau	230. BURIAL (REMATION, REMOVAL (Spacify) Burial July 6, 1967 Methodist Cemetery Uniontown, Carroll, Marylan
VR A15 (4) 20 M 1/66	24. FUNERAL DIRECTOR KN AL Skiles ADDRESS 250. REC'D BY REGISTRAR 1963. REGIST



		Division of STATISTICA					ARTMENT OF HI W. PRESTON STRE		TIMORE, MAR	LAND 2	1201	
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		o. CITY OR TOWN (If autside carparote limits, write RIRAL and give neorest town) SYRESVILLE			mo 10 da.	11	c. CITY OR TOWN (If ou WASHINGT			URAL ond g	ive neorest	tawn)
		NAME OF HOSPITAL OR INSTITUTION (IF not in SPRINGFIELD STATE HOSE			oddress)		d. STREET ADDRESS 3420 16t	h St	reet, N.W			ON A FARM?
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	13.	Stanley Frye Kark	cg)				14. MOTHER'S MAIDEN N Angela		ony			
	IS. (Yes	was DECEASED EVER IN U.S. ARMED FORCES? s, no, or unknown) (Iff yes give war or dates of ser yes 1959-62	vice) 16. S	ocial sec nkno	29920		ORMANT SPRINGFIEL	D HO		ress CORDS		
		1B. CAUSE OF DEATH (Enter only one cause po PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _	er line for	(a), (b), a	Alley	1	ua				INTE	RVAL BETWEEN ET AND DIATH
		Gonditions, if ony, which gave rise to immediate cause (a), (b)	S	14	ingal	Va	lias B	4/	Lange	ul		
		stating the underlying cause DUE TO (c)			1.				1			
2	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTR Schizophrenic react:					TERMINAL DISEASE CÓN	IDITION G	IVEN IN PART 1(o)	10		WAS AUTOPSY PERFORMED?
	L CERTIFICATION	200. EXTERNAL CAUSE WAS PRIMARY ☐ GONTRIBUTING ☐ CAUSE OF DEATH.		cribe Ho	W INJURY OCCURRE	ED. (En	iter nature of injury in I	Part I ar I	Part II of item 1B.)			
	MEDICAL	20c. TIME OF INJURY, Manth, Day, Year Haur a.m. 11:05	20d. IN While at wark		While Work 100 Ho	PLACE factory OSP	OF INJURY (Hame, farm , street, office bldg., etc.) ital	, 20f	. (City or town) SPRINGFIE	,	aunty)	(State)
		21. I certify that I taak charge of death resulted from: Natural co					Homicide CHIEF MEDICAL	, EXAMINER	Undetermined	nanner		in my opinio
7		SIGNATURE CONTROL STANDARDIS	ichex	, M.	D.	le	ASSISTANT MEDICAL DEPUTY MEDICAL DIRECTION OF THE PER CONTROL OF THE P	L EXAMIN	ER 🔀	ont	19-	2. DATE SIGNE
	C	BURIAL, CREMATION, 23b. DATE THEREOI REMOVAL (Specify)		23c. N	FORT L		EMATORY 2 O LN GEN	23d. B/	LOCATION (City or TADENSBU	RG-1	MAR	verm YLANI
1	1	IW Chamalen Con	R	nie	ADDRESS	4	DATE JL		7 1967	KEĞİSTRAR'S		judge

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09394 09394 CERTIFICATE OF DEATH filled in by the funeral n papers. Pages 1 and 2 ithin 72 hours after death. requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. STATE Maryland a. COUNTY COUNTY Carroll Allegany MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)
Syke sville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give neorest town) lvr.9dys. Corriganville e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital None NO To YES NAME OF Middle 4. DATE Year DECEASED OF DEATH LOUISE MAE GAREY 20 19 67 JULY (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH S. SEX 6. COLOR OR RACE 54 last birthday) 7. MARRIED NEVER MARRIED Months Days Hours 4-8-13 White and in any Female WIDOWED DIVORCED 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done during mast of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? INDUSTRY None Maryland

14. MOTHER'S MAIDEN NAME TI.S.A 13. FATHER'S NAME Richard Sourbrine Minnie Ruby 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 214-05-7018 Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line far (o), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: burial-transit ONSEL AND DEATH IMMEDIATE CAUSE (a) Acute myocardial infarction signed by **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital or attending physician. Acute coronary artery occlusion Days Conditions, if ony, which gave rise ta immediate cause (a), DUE TO for use as the k f Health priar ta b stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, paranoid type NO DC 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While at wark at wark 7-20-67, 19___, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceosed from_ 7-13-66 7-20-67 19 , and that deoth occurred of 100 My from causes and on the date stated above. shauld sow the deceased olive on 220. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING 7-20-67 M.D. DIRECTOR 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S Agustin del Campo, M.D. NAME (Type) Sykesville Maryland directar, g 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) 23a. BURIAL, CREMATION, REMOVAL (Specify) La Vale, Md. CAsh Valley July 23. Rest LAwn Memorial Garden 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR DATE JUL 26 VR A15 (4) 20 M 1/66 196

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09395 09395 CERTIFICATE OF DEATH and 2 24 hours after deoth 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ond completely filled in by the funeral remove corbon popers. Pages 1 and 1. PLACE OF DEATH b. COUNTY o. COUNTY o. STATE Carroll Maryland ter MARYLAND b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) popers. Pages Rural -Sykesville 3v. 9m. 12d. Baltimore d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Springfield State Hospital 1671 Argenne Drive YES NO K requires that the death certificate be executed within NAME OF Middle 4. DATE Month Day Year and in any event, with DECEASED 19 67 Brockenbrough Garland 19 Emma DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. SFX DATE OF BIRTH 9. AGE (In years 6 COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Days Hours 6/29/85 white female DIVORCED WIDOWED 11. BIRTHPLACE (Caunty & State, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR during most of working life even if retired)
Buyer - Retired Hutzler COUNTRY? ottending physician permit. Then please USA Co. Virginia 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Sallie Frances Brent Moore Brockenbrough Garland 16. SOCIAL SECURITY NO. 17 INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, no, or unknown) (If yes give wor or dates af service 10 Springfield Hospital records, Sykesville, Md. 215-10-6001 no cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) signed by the buriol-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY Cardiac failure IMMEDIATE CAUSE (a) DUF TO Conditions, if any, which gave Arteriosclerotic cardiovascular disease vears rise ta immediate couse (a), DUE TO stoting the underlying couse Page 4 may be retained by the hospital or attending DEUNERAL DIRECTOR: After this certificate has been os the lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis 19. WAS AUTOPSY PERFORMED? of Heolth NO K without qualifying phrase.

DENT WAS LINDERLYING (205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Part II af item 18.) for 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (County) (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) OR ATTENDING 7/19/__, 1967, that (x) (we) last 21. I certify that 2) (this haspital) attended the deceased fram . 19 63 . ta should 1967, and that death accurred at 6.1,5%, from causes and an the date stated above. 7/19/ saw the deceased alive an 22b. DATE SIGNED 7/19/67 22a. SIGNATURE ATTENDING X Sherreld M.D. DIRECTOR PHYS. director, page 3 should be filed v Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Sherrill C. Cheeks. M. D. Sykesville, Maryland 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) Lorraine Park Woodlawn Balto Co . .
Y REGISTRAR | 2Sb. REGISTRAR'S SIGNATURE 0 Burial 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) H.W. Jenkins & Sons Co. 4905 York Rd. DATE JUI 20 20 M 1/66

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A SECTION AND ADDRESS

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£ 24	09396 CERTIFICATE OF DEATH 09396
de att	PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission
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	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Write RURAL and give nearest town) ZOVEAR WESTMINSTER
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The law requires that the death certificate be executed within 2 or attending physician. Cate has been signed by the attending physician and completely fill ruse as the burial-transit permit. Then lease remove carbon pareaith prior to burial, cremation, or removal, and in any event, within	NAME DF First Middle Last 4. DATE Month Day Year DECEASED (Type or print) JOHN STONED GENMAN DEATH STRY 15 1967
ted comp	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HE
executed and con remove	MALE WHITE WIDOWED DIVORCED SEPT 16 1896 70 yrs. Months Days Hours Mir
scian e	Oa. USUAL OCCUPATION (Give kind of work done Industry) 12. CITIZEN OF WHAT COUNTRY? 13. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
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eath certifica attending ph ermit. Then in, or removal	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT STONER GADOS MAN JR.
e dea the a it pen	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
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OR ATTENDING PHYSICIAN: The law requires that the be retained by the hospital or attending physician. DIRECTOR: After this certificate has been signed by ge 3 should be detached for use as the burial-transed with the State Dept. of Health prior to burial, created with the State Dept.	20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19 And While at work at w
ATTENDING PR retained by th CTOR: After t S should be de vith the State	
TENDI tained OR: A hould h the	21. I certify that (I) (this hospital) attended the deceased from 1957, that (I) (we) lass with the deceased alive pp. 1957, and that death occurred at 2.5 M, from the causes and on the date stated above
NAL OR ATTERNAY be retain any be retain at DIRECTON page 3 shows filed with the state of the sta	22a. SIGNATURE 22b. DATE SIGNED
AL O nay t nay t nay t nay t page	22c. PHYSICIAN'S ATTENDING MED. STAFF DIRECTOR PHYS. DIRECTOR PHYS. DIRECTOR DIRECT
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transi should be filed with the State Dept. of Health prior to burial, crem	MANNIEL I. WELLIVER WESTMINSTER MI
Pag Pag TO Fu dire	3a. BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
2	44. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15 (4) 15M 4-64	J. E. myers of Westminter, md. DATEJUL 17 1967 Jollanes Judges
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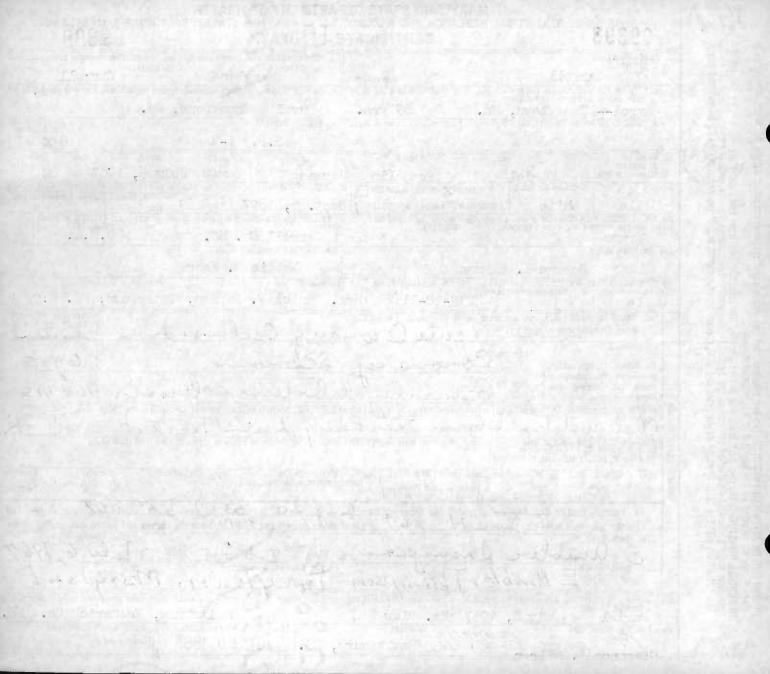
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	MARYLAND STATE DEPARTMENT OF HEALTH	
	Division of STATISTICAL RESEARCH AND RECORDS, 301, W. PRESTON STREET, BALTIMORE, MARYLAND 21 Item #8 & 9 Film #G390 7/10/67 pg.	
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MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE J, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. death 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY after Carroll Carroll Maryland the MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pag hours Rural -- Taneytown, Md. 69 Rural Tanevtown. Md. Ξ yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filled e. IS RESIDENCE ON A FARM? d. STREET ADDRESS n and completely filli remove carbon pap in any event, within 7 R.D.# YES X NO within 3. NAME OF DECEASED First Middle Last DATE Month Day Year 4. 0F 1967 (Type or print) DEATH July 19 Franklin Harman Danie executed 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED TO NEVER MARRIED last birthday) Months | Sept. White M ale 6. WIDOWED DIVORCED se i 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) been signed by the attending physician the burial-transit permit. Then please in or to burial, cremation, or removal, and in death certificate be during most of working life, even if retired) COUNTRY? INDUSTRY U.S.A. Carroll Co. Md. Farmer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Nettie N. Kehn George I. Harman 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. (Yes, no, or unkown) (If yes give war or dates of service) 219-20-3152 Mrs. Daniel F. Harman, Taneytown, Md. R.D# 18. CAUSE OF DEATH [Enter only one cause per line for, (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) the hospital or attending physician. Conditions, If any, which for use as the b f Health prior to b gave rise to immediate DUE TO stating underlying cause last. O FUNERAL DIRECTOR: After this certificate has director, page 3 should be detached for use as should be filed with the State Dept. of Health pric (c) CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT PERFORMED? NO NO YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Inter nature of injury in Part I or Part II of Item 18.) MEDICAL (State) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m. Not While at work While p.m. at work be retained 21. I certify that (I) (this hespitel) attended the deceased from and that death occurred at 8:10 PM, from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE ATTENDING PHYS. STAFF Page 4 may b M.D. DIRECTOR PHYS. PHYSICIAN'S NAME (Type) 22d. ADDRESS LOCATION (City, town or county) BURIAL, CREMATION, REMOVAL (Specify) NAME OF CEMETERY OR CREMATORY 23d. (State) 23b. DATE THEREOF 9 Emmitsburg. Mt. View Frederick Co. Burial REC'D BY REGISTRAR REGISTRAR'S SIGNATURE ADDRESS 25b. FUNERAL DIRECTOR Emmitsburg, Md. 15M 4-64



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09400 CERTIFICATE OF DEATH 09400 the attending physician and campletely filled in by the funeral sit nermit. Then please remave carbon papers. Pages 1 and 2 sit nermit. Then please remave carbon papers. PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY b. COUNTY o. STATE Maryland Carroll Pr. George Co. MARYLAND b. CITY OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town)

Sykesville Lakeland davs 02.1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Springfield State Hospital YES NO Middle NAME OF First 4. DATE Month Doy Year DECEASED HAWKINS 1967 James Oscar DEATH July (Type or print) 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Hours 12-25-1902 WIDOWED DIVORCED male nergo 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? **INDUSTRY** Maryland U.S.A Laborer 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Marv - dec. - dec 16. SOCIAL SECURITY NO. 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 056-16-7041 Springfield State Hospital Records no crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p burial, crematic ONSET AND DEATH PART I. DEATH WAS CAUSED BY Aspiration bronchopneumonia, source unknown IMMEDIATE CAUSE (o) 4200 DUE TO Years Arteriosclerotic heart disease Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital ar attending TO FUNERAL DIRECTOR: After this certificate has been is as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Inactive, multiple tuberculous cavities. 19. WAS AUTOPSY PERFORMED? for use Health YES X NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Doy, Yeor foctory, street, office bldg., etc.) Not While at work ot work 21. I certify that (1) (this haspital) attended the deceased fram 6-2-67 ta 7-23-67, 19__, that (I) (we) last . 19 saw the deceased alive an 7-23-67 19 , and that death accurred at 1:15 Mpfsam causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING 7-23-67 PHYS DIRECTOR PHYS. director, page shauld be filed 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Sykesyllle, Maryland 2178h Julian Radzykewycz, M.D. 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify)
Burial Baltimore, Maryland Mt. Auburn 24. FUNERAL DIRECTOR **ADDRESS** REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Rice 661 W. Barre St. VR A15 (4) 20 M 1/66 Charles

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 401 09401 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH physicion and completely filled in by the funera en please remove carbon papers. Pages 1 and o. COUNTY CARROLL o. STATE Maryland b. County timore City MARYLAND b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn)

Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Baltimore e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS Springfield State Hospital 1030 N. Arlington Avenue NO A 4 DATE 3. NAME OF First Middle Month Day Year DECEASED JACKSON MORIAH MMN 1967 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED irthdoy) Months Hours Female Negro WIDOWED K 12-25-1886 DIVORCED 10a. USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign country) 12. CITIZEN OF WHAT COUNTRY?S.A. during most of working life, even if retired) INDUSTRY Virginia 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Rawleigh Smith Elizabeth Smith 16. SOCIAL SECURITY NO 17. INFORMANT Records Sykesville, 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates af service) 220-54-6011 Springfield State Hospital Maryland 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the buriol-transit p ONSET AND DEATH PART 1. DEATH WAS CAUSED BY: Coronary Occlusion or Myocardial Infarction IMMEDIATE CAUSE (o) DUE TO 24 hrs. Senility, generalized Arteriosclerosis Conditions, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying cause prior to O FUNERAL DIRECTOR: After this certificate hos been os the Encephalomalacia 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g)

Chronic brain syndrome associated with cerebral arteriosclerosis with NO X YES psychotic reac for 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 ar Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER' 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Nat While factory, street, office bldg., etc.) at work at wark TO HOSPITAL OR ATTENDING Page 4 moy be retained by pe 3-24, 1964 pta , 19<u>67</u>, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram 3-21, 1964 pta 7/11, 1967, that (I) (we) last saw the deceased alive an 7/11 1967, and that death accurred at 9:30 M, fram causes and an the date stated above. should 22a SIGNATURE 22b. DATE SIGNED 7/12/67 ATTENDING PHYS. STAFF PHYS. rendal DIRECTOR Springfield State Hospital 22c. PH/SICIAN'S 22d. ADDRESS I. Esendal, M.D., Staff Psychiatrist NAME (Type) Sykesville, Maryland director, 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, (County) (State) REMOVAL (Specify) 7-15-67 Mount Auburn Cem Baltimore, Maryland Buria 256 PECUSTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 196 DATE JL 14 MORTON & DYETT F.H. 1701 Laurens St.

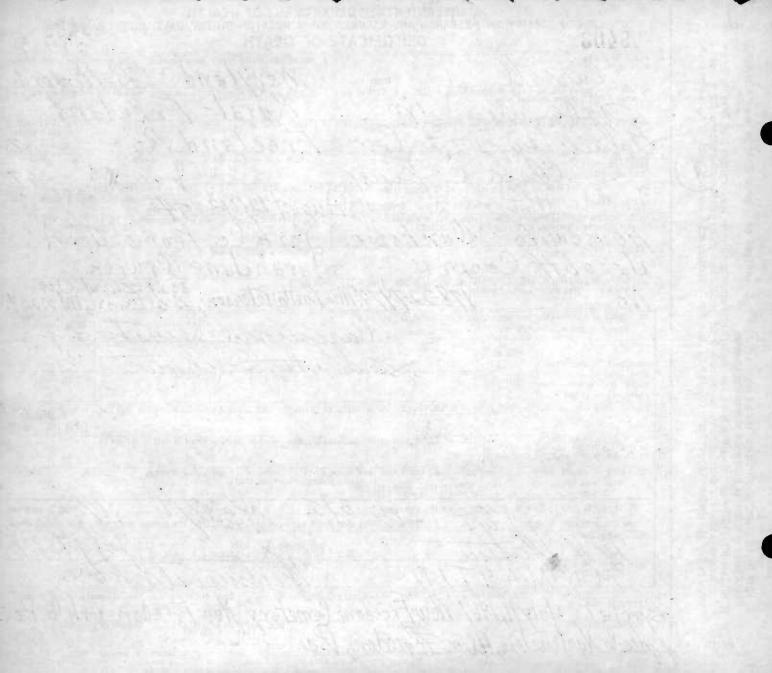
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09402 CERTIFICATE OF DEATH by the attending physician and campletely filled in by the funeral transit permit. Then please remave sarban papers. Pages 1, and 2 transit permit. requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY b. COUNTY Carroll Maryland MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) write RURAL and give nearest tawn)

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(Yes, no, or unknown) ((If yes give wor or dates of service) 17. INFORMANT Address 16 SOCIAL SECURITY ND 219-01-1923 Records, Springfield State Hospital no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY Heart Failure IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove Old Infarct: Coronary arteriosclerosis vears rise ta immediate cause (a), DUE TO stoting the underlying cause **O HOSPITAL OR ATTENDING PHYSICIAN:** The law re Page 4 may be retained by the hospital ar attending has been days Broncho pneumonia PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? w/cerebral arteriosclerosis w/psychotic reaction. YES X NO TO FUNERAL DIRECTOR: After this certificate C.B.S. assoc. far 20g. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH af detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City ar town) (County) (Stote) 20c. TIME OF INJURY Manth, Doy, Year Haur a.m foctory, street, office bldg., etc.) Nat While at wark at wark . 19 65 , ta. 21. I certify that (I) (this haspital) attended the deceased fram. , 19___, that (I) (we) last 1-19shauld and that death occurred at 9 a.M. from causes and on the date stated above. saw the decepsed alive pn_ 19 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. Ernes director, page 3 shauld be filed M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Springfield State Hospital, Sykes., Md. 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City or Town) (County) (State) 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) ATTIMORE BURIA 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR VR A15 (4) 1967 Villandas 3035 W. NORTH

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F 4 F 0 1		NAME (Type)	19T/N	22	Herry	uniles h	M.
O HOS Page O FUN direct	238	BURIAL, CREMATION, 23b. DATE	THEREOF 230. NAME	OF CEMETERY OR CR	REMATORY 2	d. LOCATION (City, town o	or county) (State)
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20M 1/65	77	7114	7	-			



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09404 CERTIFICATE OF DEATH 09404 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) within 24 hours after deat PLACE OF DEATH o. COUNTY arroll o. Maryland Baltimore City MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) signed by the attending physician and campletely filled in by the burial-transit permit. Then please remove carron papers. Panes burial, crematian acremoval and see b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 601 Ponca St., Baltimore Sykesville uvrs. 25dvs. event, within 72 hau d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 601 Ponca St. Springfield State Hospital YES | NO X NAME OF Middle Lost 4. DATE Month Doy Year DECEASED (Type or print) (NMN) KOLODZIEJ JULY ALBERT 67 19 DEATH requires that the death certificate be executed DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Doys Hours 1-11-03 White WIDOWED DIVORCED Male 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done U.S.A. during most of working life, even if retired) INDUSTRY New Jersev 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Bartholomew Kolodziej Sofia (last name unk.) 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) [If yes give wor or dotes of service]
Les 1928-1943 17. INFORMANT 16. SOCIAL SECURITY NO. 214-24-4851 Records, Springfield State Hospital INTERVAL BETWEEN ONSET AND DEATH Weeks 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY:
IMMEDIATE (AUSE (o) Metastatic carcinoma, left side of neck (lymph DUE TO Conditions, if ony, which gove Months (b) Squamous cell carcinoma of larvnx rise to immediate couse (o), DUE TO stoting the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? CBS assoc. with cerebral arteriosclerosis, without qualifying phrase far use Health NO X 20o. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. foctory, street, office bldg., etc.) Not While of work of work 21. I certify that (1) (this haspital) attended the deceased fram 6-19-63 ____, that (i) (we) last ta-7-14-67 shauld 19____, and that death accurred at 6:10 M, fram causes and an the date stated above 7-14-67 saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE ATTENDING STAFF PHYS. 7-18-67 M.D. PHYS. director, page 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S Octavio A. Ruiz, M.D. NAME (Type) Sykesville, Maryland should 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL CREMATION REMOVAL (Specify) Sykpsville treedom 25b. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR ADDRESS FUNERAL DIRECTOR Milianles VR A15 (4) 20 M 1/66 1967 DAT

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. 09406 CERTIFICATE OF DEATH death, low requires that the death certificate be executed within 24 hours after death attending physicion ond completely filled in by the funeral permit. Then please remove carbon papers. Pages 1 and on ar removol, and in any event, within 72 haurs after deathon. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Carroll o. COUNTY a. STATE Maryland Carroll MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) Tanevtown Taneytown d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? 66 York Street 66 York Street YES NO TO NAME OF First Middle 4. DATE Month Year Doy DECEASED Annie DEATH July 1967 Alverta Koutz (Type or print) SEX 9. AGE (In years IF UNOER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH NEVER MARRIED birthday) Manths Davs Haurs WIDOWED DIVORCED March 1, 1880 Female White 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (Caunty & State, or foreign country) during most of working life, even if retired) INDUSTRY **COUNTRY?** Silver Run, Maryland
14. MOTHER'S MAIDEN NAME Housewife Own home U.S.A 13. FATHER'S NAME Ellen Smeak Theodore Bankard WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT permit. (Yes, na, ar unknawn) (If yes give war ar dates af service Mrs. Romaine Motter. Taneytown, Maryland No 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)PART 1. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the buriol-transit p IMMEDIATE CAUSE (o) DUF TO Conditions, if any, which gave rise to immediate cause (o). DUE TO stating the underlying couse ottending os the TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO Page 4 may be retoined by the hospital ar to 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour o.m. factory, street, affice bldg., etc.) Not While ot wark of work __, 1967 that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram \$\lefts\$ and that death accurred above. M, fram lauses and an the date stated above. 1967 saw the deceased alive an. 10/30 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF M.D. DIRECTOR PHYS PHYS. 22d. ADDRESS-22c. PHYSICIAN'S directar, po should be f NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Reformed Cemetery Tanevtown Carroll, Maryland Burial 256. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Taneytown, Marylan PATE C.O. Fuss & Son

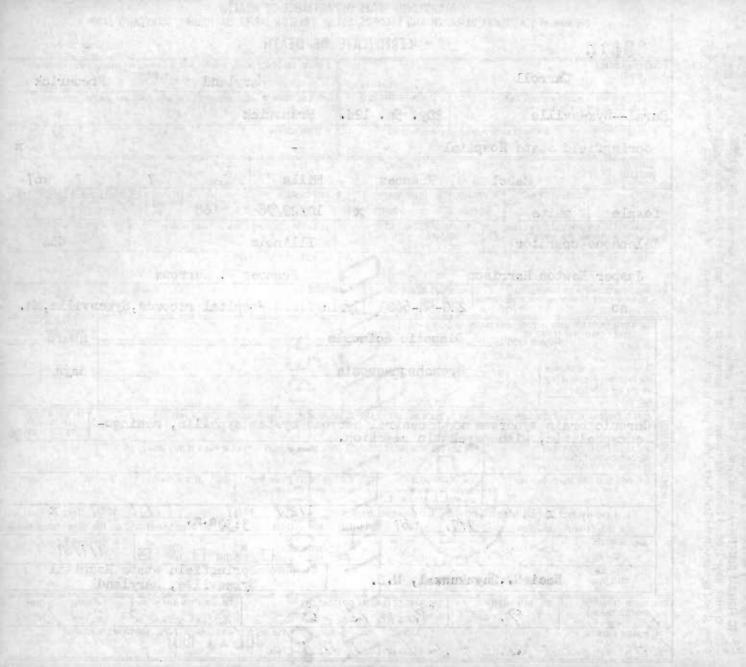
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09409 The law requires that the death certificate be executed within 24 hours after death. I PLACE DE DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 000 o. COUNTY o. STATE b. COUNTY Carroll Carroll MARYLAND physicion and completely filled in by the nen please remove corban papers. Pages oval. and it onv event, within 72 hours at b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparote limits, write RURAL and give nearest tawn) write RURAL and give nearest town) Westminster Hampstead e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS R. D. 2 Carroll Gounty General Hospital YES NO [3. NAME OF 4. DATE Middle Month Doy Year Lost DECEASED 19 67 Katharine Loots July event, Marie (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE X 7. MARRIED NEVER MARRIED birthday) Months Dovs Hours April 29, 1900 ony WIDOWED DIVORCED White Female 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during most of working life, even if retired)
Housewife INDUSTRY Balto. City 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Katharine Ritz Frederick Kinstler 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 216-52-5715 Mr. Charles A. Loots Hampstead. Md. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) cremoti buriol-tronsit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by DUE TO Arteriorchestic Hent Duen Conditions, if ony, which gove rise to immediate couse (o), DUE TO offending | stoting the underlying couse prior to O FUNERAL DIRECTOR: After this certificate hos been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? use NO 4 YES the hospital or 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour o.m. Not While foctory, street, office bldg., etc.) ot work pe be retained by e deceased from Journe 24, 19 62, ta July 2, 19 67 that (1) (we) last 19 67, and that death occurred at 2:40 M, from causes and an the date stated abave. 21. I certify that (1) (this haspital) attended the deceased from Journe 24 saw the deceased olive an 220. SIGNATURE 22b. DATE SIGNED DIRECTOR 22d. ADDRESS 22c. PHYSICIÁN'S director, po should be f NAME (Type) HARSHEY 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23b. DATE THEREOF 23o. BURIAL CREMATION. Burial (Specify) Hampstead. Md. July 6. 1967 Grace Cemetery 25o. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR 1967 VR A15 (4) 20 M 1/66 Tipton-Eline Funeral Home Hampstead, Md. DATUL 5 Charles

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY RROLL MARYLAND b. CITY OR TOWN (If outside corporate limits c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town write RURAL and give nearest town ESTMINSTE physician and campletely filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS ON A FARM YES NO X NAME OF DATE First Middle Lost Doy Year DECEASED OF DEATH 19 (Type or print) ent, AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH remave last birthdoy) Months Doys Hours in any WIDOWED DIVORCED 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stole, or foreign country) 12. CITIZEN OF WHAT please during most of working life, even if retired) INDUSTRY FARMER 13. FATHER'S NAME 14. MOTHER'S MAIDEN ar removal, en WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO burial, netostatici Carcino Conditions, if ony, which gove rise to immediate couse (o), DUF TO stoting the underlying couse the haspital or attending as the prior tal **DIRECTOR:** After this certificate has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? PHYSICIAN: The use YES TE NO far 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20c. TIME OF INJURY Month. Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) foctory, street, office bldg., etc.) Not While ot work ld be 21. I certify that (I) (this haspital) attended the deceased from 1962, that (I) (we) last 1960 > ta be retained and that death accurred at 4 M, fram causes and on the date stated above. saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS. 22d ADDRESS 22c. PHYSICIAN'S O FUNERAL NAME (Type) OHNE directar, shauld 23b. DATE THEREOF. 236 BURIAL CREMATION 23d. LOCATION (City or Town) (Stote) 23c. NAME OF CEMETERY OR CREMATORY (County) REMOVAL (Specify) REGISTRAR'S SIGNATURE 2. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Marley

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09412 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Carroll MARYLAND Marvland please remave carbon papers. Pages I, and in any event, within 72 hours after b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 the attending physician and campletely filled in by the sit permit. Then please remave carbon papers. Pages c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville Baltimore 21215 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e. IS RESIDENCE ON A FARM? d STREET ADDRESS Springfield State Hospital 3312 Hayward Avenue YES NO DC 3. NAME OF Middle 4. DATE Year DECEASED John MOONEY July Malcolm 1967 (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. B. DATE OF BIRTH S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Hours DIVORCED DE 2-4-1904 male white WIDOWED 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) State Roads COUNTRY? U.S.A Auto Mechanic Maryland

14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Charles W. Mooney - dec. Mary E. Kendrick - dec. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service 218-05-9912 1/3 1942-1943 Springfield State Hospital Records. ves crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Squamous cell carcinoma of esophagus. mos. IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) ed for use of Health p CBS assoc. with alcoholic intoxication with psychotic reaction. NO PO 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED (County) Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 7-22-67, 19___, that (I) (we) last 21. I certify that (4) (this haspital) attended the deceased fram_ 2-5-65 shauld saw the deceased alive, an 7-22-67 19 , and that death accurred at 5:30M. Front causes and an the date stated above. 22b. DATE SIGNED 220 SIGNATURE ATTENDING M.D. DIRECTOR PHYS. directar, page 3 should be filed v 22d. ADDRESS Springfield State Hospital 22c PHYSICIAN'S NAME (Type) M. Schoolman. M.D. Sykesville, Maryland 21784 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify)
Burial Cathedral Cemetery Baltimore, Md. 7/25/1967 250. REC'D BY REGISTRAR 967 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR

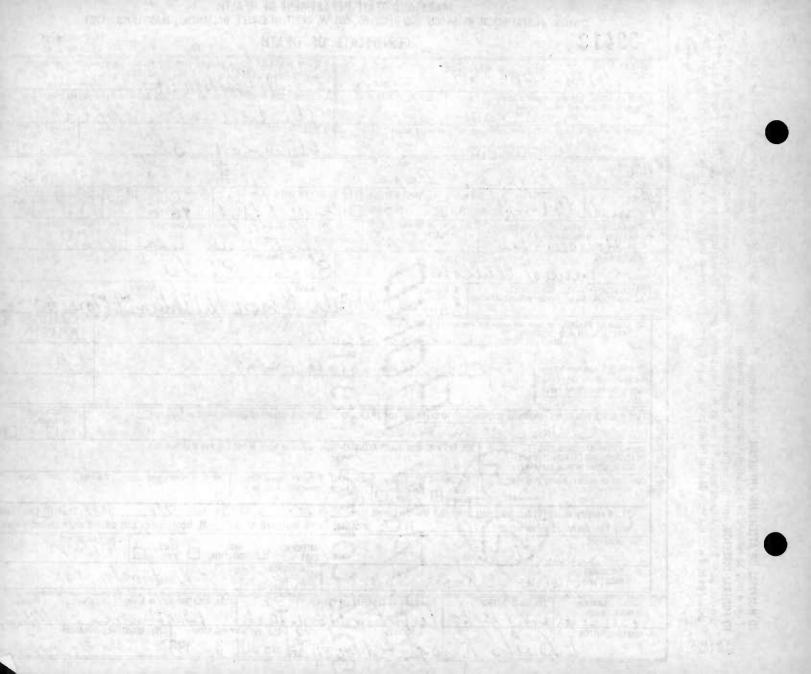
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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE. MARYLAND 21201 09413 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death pup 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) PLACE OF DEATH funerol o. COUNTY b. COUNTY CARROLL MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits write RURAL and give negrest town) WESTMINSTER IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) YES NO UNTON STREET 3 NAME OF Middle 4. DATE Year First Lost Doy DECEASED OF MMA 67 19 COL (Type or print) DEATH IF INDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS. 6 COLOR OR RACE 7. MARRIED DATE OF BIRTH NEVER MARRIED lost birthdoy) Months Dovs Hours WIDOWED 12 DIVORCED and in ony puo 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTAPLACE (County & State, or foreign country) physician o COUNTRY? during most of working life, even if retired) INDUSTRY Houseur 13. FATHER'S NAME MOTHER'S MAIDEN NAMI or removol, ottending phys 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 17. INFORMAN Address 16. SOCIAL SECURITY NO. cremotion, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH signed by the buriol-tronsit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Poge 4 may be retained by the hospital or ottending physician. DUE TO buriol, Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse Heolth prior to last. 00 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 10 comprestion NO A certificote 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20d. INJURY OCCURRED (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor TO FUNERAL DIRECTOR: After this Hour a.m. foctory, street, office bldg., etc.) Not While of work . 1921, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. 1953 to 1967, and that death occurred at 3 P. M. fram causes and an the date stated above. saw the deceased alive an 22o. SIGNATURE **ATTENDING** director, poge 3 should be filed v M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) heoko 230. BURIAL, CREMATION, 23b. DATE THEREOF 235 NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 SE DATE JU



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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY n. STATE 2, onu PM3. Page b. COUNTY of death. MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give neorest tawn) after HOSPITAL OR INSTITUTION of not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ote De he Chief Medicol Examiner's Office olong with farm in Item 18. Give Poges 1, NO F 24 hours after death. NAME OF Middle 4. DATE Lost Manth Dov Year 72 DECEASED the (Type ar print) DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Haurs DIVORCED WIDOWED puo Ing IISUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? penci _ and 17. INFORMANT permit. (Yes, no, ar unknown) (If yes give war ar dates of service removal, 18. CAUSE OF DEATH (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: buriol-tronsit 0 IMMEDIATE CAUSE (o) certificate shauld writing the word cremation, Conditions, if any, which gave forwarded to rise to immediate cause (a), DUE TO 0 stating the underlying couse last. used 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) YES NO 9 be 20a. EXTERNAL CAUSE WAS 3 should l prior PRIMARY Cor CONTRIBUTING CAUSE OF DEATH. should 20c. TIME OF INJURY Manth, Doy, Year 20e PLACE OF INJURY (Hame, farm, factory street, affice bldg., etc. FUNERAL DIRECTOR: Poge at wark 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry ond in my opinion 0 the funerol director. deoth resulted from: Natural couses Suicide Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER **EXAMINER'S** Heolth NAME (Type) BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 0 EMNERAL DIRECTOR VR A15ME (5) 6M 1/66

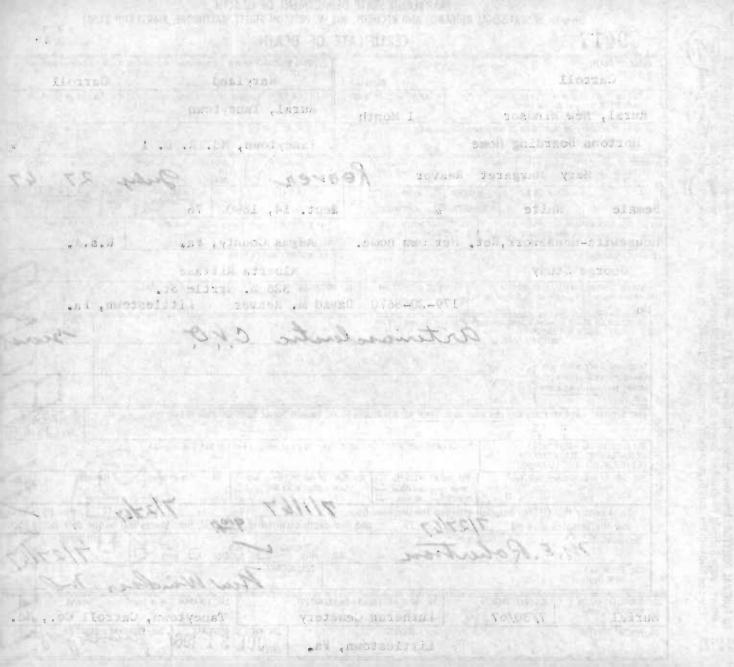
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE. MARYLAND 21201 CERTIFICATE OF DEATH 09416 funeral s 1 and 2 ter death. within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY CARROLL o. STATE b. COUNTY MARYLAND in by the Pages c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 days THURMONT e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS SPRINGFIELD STATE HOSPITAL ROUTE # YES NO IX Middle 4 DATE Dov Year NAME OF First Lost DECEASED CHARLES 67 MEDWELL RAMSRURG 19 DEATH (Type or print) requires that the deoth certificate be executed IF UNDER 1 YEAR IF UNDER 24 HRS. ever 8. DATE OF BIRTH AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED pleose remove lost birthdoy) Months Dovs Hours Male White 8/21/1872 WIDOWFD DIVORCED ond in any 12. CITIZEN OF WHAT KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 10a. USUAL OCCUPATION (Give kind of work done 10b. COUNTRY? during most of working life, even if retired) INDUSTRY ottending physicion permit. Then pleose Maryland Laborer 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, SAVELLA BAUGHTER DANTEL RAMSBURG 17 INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no or unknown) (If yes give wor or dotes of service) permit. SPRINGFIELD STATE HOSPITAL RECORDS 215-20-9360 buriol, cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) ONSET AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY CONGESTIVE HEART FAILURE IMMEDIATE CAUSE (o) DUE TO signed ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 8 yrs. Conditions, if ony, which gove rise to immediate couse (a), DUE TO r this certificate has been si detached for use as the b te Dept. of Health prior to b stoting the underlying couse be retained by the hospital or ottending lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic Brain Syndrome assoc, with circulatory disorder with psy. reacts 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (County) 20e. PLACE OF INJURY (Home, farm, (City or town) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While ot work ot work O FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram_ 6/19 19 67 ta 19 6 (that (1) (we) last should 19 67, and that death occurred at 9:15PM, from causes and an the date stated abave. sow the deceased alike/an 22b. DATE SIGNED 22o. SIGNATURE 7/13/67 M.D. PHYS DIRECTOR PHYS. director, poge 3 should be filed 22d. ADDRESS 22c. PHYSICIAN'S Page 4 moy Springfield State Hospital NAME (Type) Alberto Arengo, M.D. director, 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Jown) (County) (Stote) 23o. BURIAL, CREMATION 23b. DATE THEREOF REMOVAL (Specify) REGISTRAR'S SIGNATUR 24. FUNGRAL DIRECTOR REVINO AND 2So. REC'D BY REGISTRAR 2Sb. VR A15 (4) 20 M 1/66

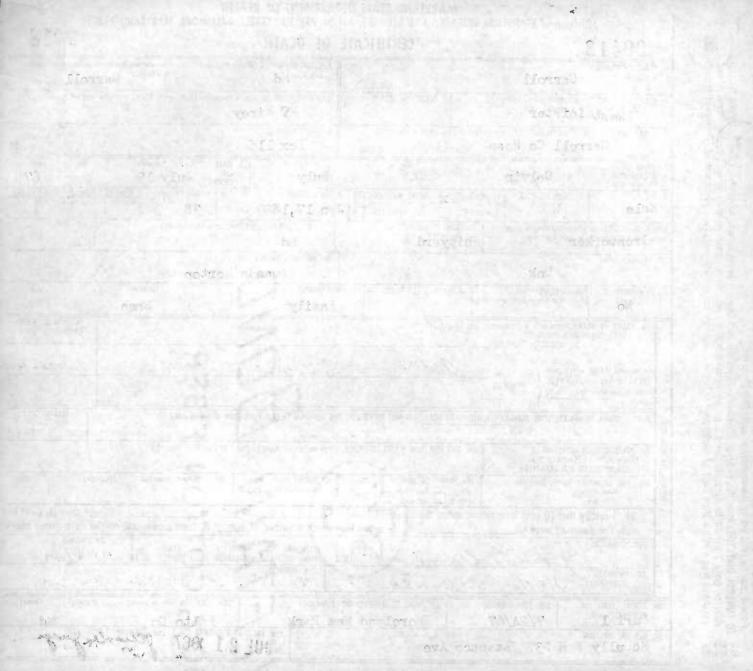
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09417 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a. COUNTY Carroll b. COUNTY Maryland Carroll MARYLAND Pages b. CITY OR TOWN (If autside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) filled in by the papers. Page write RURAL and give nearest tawn) Rural. Tanevtown Rural, New Windsor 1 Month d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspitol, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Hortons Boarding Home Taneytown, Md. R. D. 1 YES NO SE 3. NAME OF Middle DATE Month Day Year completely (Type or print) Mary Reaver Margaret DEATH removered eveni 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED 76 birthdoy) Months Dovs Hours White and in only Female. Sept. 14, 1890 WIDOWED 4 DIVORCED puo 11. BIRTHPLACE (County & State, ar foreign country) 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during mast of working life, even if retired)
Housewife-Housework industry Her own home. COUNTRY? Adams County . Pa. U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol, attending phys George Study Alberta Rittase 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 326 W. Myrtle St. Address (Yes, no, or unknown) (If yes give war ar dates af service) 179-20-8670 David M. Reaver Littlestown, Pa. No buriol, cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the buriol-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) be retoined by the hospital or attending physicion. DUE TO Canditians, if any, which gove (b) rise to immediate cause (a). DUE TO stoting the underlying cause as the prior to last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Health 1 NO ATTENDING PHYSICIAN: 0 200 ACCIDENT WAS LINDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City ar tawn) (County) (Stote) TO FUNERAL DIRECTOR: After this Hour a.m. foctory, street, office bldg., etc.) Nat While at work ot work 21. I certify that (I) (this hospital) attended the deceased fram 19___, that (1) (we) last directar, page 3 should should be filed with the and that death accurred at 960 M, fram causes and on the date stated obove. saw the deceased alive on_ 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. M.D. PHYS DIRECTOR TO HOSPITAL (Page 4 moy b 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (State) Burial (Specify) 7/30/67 Lutheran Cemetery Taneytown, Carroll Co. Md. 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATUR FHINERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66 Littlestown, Pa-

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09418 The law requires that the death certificate be executed within 24 hours after death. funeral I and 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH de a. STATE MA b. COUNTY a. COUNTY Carroll Carroll MARYLAND c. CITY OR TOWN (If gutside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits, Westmaniesterm My Airev e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) the attending physician and completely (filled in sit permit. Then please remave carban bapers event, within 72 60 Carroll Co Hosp Box 115 NO M YFS Middle Last 4 DATE Manth Year NAME OF First DECEASED 19 67 Calvin Ruby July 19 DEATH (Type ar print) IF UNDER 1 YEAR LIF LINDER 24 HRS. DATE OF BIRTH AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Manths Days Haurs Mala W Jan 17.1889 and in any WIDOWED DIVORCED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 10a. USUAL OCCUPATION (Give kind of work dane COUNTRY? during meet of working life, even if retired) Shipward Md 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remaya Unk Amanda Horton Address 16. SOCIAL SECURITY NO. 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ownknawn) (If yes give wor or dates of service) Same Family INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) burial-transit ONSET AND DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by 1 arterioscleratio Spart Disease DUE TO Canditians, if ony, which gave rise ta immediate cause (a), DUE TO stoting the underlying cause TO FUNERAL DIRECTOR: After this certificate has been as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (County) (Stote) (City or town) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Hour o.m. Nat While 19 TO HOSPITAL OR ATTENDING Page 4 may be retained by the at work at wark 21. I certify that (1) (this hospital) attended the deceased from_ Green, 12, 1967, to July 19, 1960, that (1) (we) last and that death accurred at 245 PM, fram causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE 4 PHYS. M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S HARSHIYM.D. Laucher NAME (Type) directar, shauld 23d. LOCATION (City or Tawn) (Stote) 23c. NAME OF CEMETERY OR CREMATORY (County) 23o. BURIAL CREMATION. 23b. DATE THEREOF BEMOYAL (Specify) 7/24/67 Moreland Mem Park Balto Co 2Sa. REC'D BY REGISTRAR **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 McCully F H 237 Patapsco Ave



	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1
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OR ATTENDING PHYSICIAN: The be retained by the hospital or INECTOR: After this certificate 3 should be detached for used with the State Dept. of Heal	21. I certify that (1) (this hospital) attended the deceased from
OR AT OR AT DIRECT DIRECT See 3 sl led with	22a. SIGNATURE 22b. DATE SIGNED M.D. PHYS. DIRECTOR PHYS.
TO HOSPITAL OR ATTEND Page 4 may be retained TO FUNERAL DIRECTOR: 4 director, page 3 should should be filed with the	22c. PHYSICIAN'S NAME (Type) D. A MN/6 HT ND. 22d. ADDRESS MILLINGUIST, M.
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH funeral . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b COUNTY ARROLL law requires that the death certificate be executed within 24 haurs after MARYLAND b. CITY OR TOWN (If outside corporate limits. CLENGTH OF STAY IN 16 c. CITY OR TOWN (If ourside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town d. STREET ADDRESS IS RESIDENCE ON A FARM? physician and campletely filled NO F-NAME OF Middle 4. DATE First Lost Month Dov Year DECEASED (Type ar print) DEATH S. SEX 9. AGE (In years IF UNDER 24 HRS 7. MARRIED NEVER MARRIED please remove last birthday) Manths Days Haurs WIDOWED DIVORCED OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR (County & Stote, ar fareign (auntry) 12. CITIZEN OF WHAT INDUSTRY COUNTRY ? MARKE 13. FATHER'S NAMI 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, na, ar unknown) (If yes give war ar dates af service) Ь CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART 1. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Terrosclerots Hart Descent Canditions, if any, which gove rise ta immediate cause (a), DUE TO stoting the underlying cause attending as the has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO this certificate for 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) Haur a.m. Nat While factory, street, affice blda., etc.) While 21. I certify that (1) (this haspital) attended the deceased fram. 1967, ta. 1967, that (I) (we) last be retained and that death accurred at 3.10 PM, fram causes and an the date stated above. O FUNERAL DIRECTOR: saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. DIRECTOR PHYS. directar, page shauld be filed 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) (State) 24. FUNERAL DIRECTOR 250. BEED BY REGISTRAP 967 25b. VR A15 (4 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09422 09422 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. attending physician and comptetely filled in by the funeral permit. Then please rentave carbon papers. Pages I and an, ar remaval, and in any event, within 72 hours after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY Maryland Carroll Montgomery MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 Sykesville Lyr 3m
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Livr 3mo 6da Rockville e. IS RESIDENCE ON A FARM? d. STREET ADDRESS 14210 London Lane YES NO X Springfield State Hospital 4. DATE 3. NAME OF Month Year First Lost DECEASED 19 67 Simms July Dorotht Agnes DEATH (Type ar print) IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years 8. DATE OF BIRTH S SFX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Hours 2-3-81 X WIDOWED DIVORCED White Female 10a. USUAL OCCUPATION (Give kind af wark dane during most of working life, even if refired) 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR COUNTRY? INDUSTRY Pennsylvania
14. MOTHER'S MAIDEN NAME II.S.A 13. FATHER'S NAME Mary Hart Patrick Hart 17. INFORMANT Address Sykesville 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. permit. (Yes, no, or unknown) (If yes give war or dates af service) 205-91-7001 Springfield Hospital REcord Maryland No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: ONSET AND DEATH burial-transit Heart failure IMMEDIATE CAUSE (o) DUE TO signed ! Conditions, if ony, which gave Arteriosclerotic heart disease with diffuse rise to immediate cause (a), left ventricle fibrosis DUE TO Years stating the underlying couse as the TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO with cerebral arteriosclerosis, with psychotic reaction far 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Haur o.m. Not While at wark , 19___, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram 3-28-63 , 19____, ta 7_4-67 and that death accurred at 2.1044 fram causes and an the date stated above. saw the deceased alive an 7-11-67 __19 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. **ATTENDING** MED. DIRECTOR directar, page 3 shauld be filed w 22d. ADDRESS 22c. PHYSICIAN'S Antonius Glahn, M.D. Sykesville, Maryland NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23b. DATE THEREOF 23a. BURIAL, CREMATION, REMOVAL Specify 7-7-67 Braddock Catholis Braddock Pa. 25b. REGISTRAR'S SIGNATURE 250. RECO BY REGISTRAR Robert Pumphrey 3557 Wiscomain Ave VR A15 (4) DATE 20 M 1/66

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	and the second second	A BARDER	Pag verdona 125	T ons

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. VR AIS (4)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 09423 CERTIFICATE OF DEATH

1. PLACE OF DEAT a. COUNTY	Н		2. USUAL RESIDEN	CE (Where deceased lived, If insti	tution: Residence before admission)
	Carroll	MARYLAND	a. SINIE	Md.	Carroll
b. CITY OR TOW Write RURAL	NN (if outside corporate limits L and give nearest town)	s, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (I		RURAL and give nearest town)
Hampste	ad		Ham	pstead	061
d. NAME OF HO	SPITAL OR INSTITUTION (if no	ot in hospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
	sville Road		Houdk	sville Road	YES NO
3. NAME DF DECEASED	First	Middle	Last	4. DATE Month	Day Year
(Type or print)	Paul	Raymon	Simms	DEATH July	L. 19 67
5. SEX	6. COLOR OR RACE 7. MAP	RRIED NEVER MARRIED	8. DATE OF BIRTH	19. AGE (In years III	FUNDER 1 YEAR HE UNDER 24 HRS.
Male	9 97 0 1		Feb. 17, 19	05 last birthday) N	fonths Days Hours Min.
1Da. USUAL OCCUPA	TION (Give kind of work done king life, even if retired)	10b. KIND OF BUSINESS OR		County & State, or foreign country)	12. CITIZEN OF WHAT
					COUNTRY?
13. FATHER'S NAM	& Decker Compa	ny	Balti	more City	USA
	J. Simms				
				ie R. Torbit	
15. WAS DECEASED (Yes, no, or unkown)	EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	16. SOCIAL SECURITY ND. 17.	INFORMANT	Address	
No		212-10-9630 Mr	s. Dorothy	B. Simms Hamps	stead, Md.
	DEATH [Enter only one cause			2 n .	INTERVAL BETWEEN ONSET AND DEATH
PART I. D	EATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	neta stalle (urcinna	of Brun	5mc
16-1	DUE TO		0		
Conditions, If		Simons gen	in Curo	unning,	8-9200
gave rise to	Immediate (
cause (a), s underlying cau	as fast				
		TRIBUTING TO DEATH BUT NOT REL	ATEN TO THE TERMINAL	DISEASE CONDITION GIVEN IN DA	ART 1(a) 19. WAS AUTOPSY
ATION LINE	@ 1000	7 / - 4.	in .	DISCUSE CONDITION GIVEN IN FA	PERFORMED?
2	Comme				YES NO
PART II. OTHER 2Da. ACCIDENT OR CONTRIBUT (IF EITHER, NO	WAS UNDERLYING 2 ING CAUSE OF DEATH OTIFY MEDICAL EXAMINER)	Ob. DESCRIBÉ HOW INJURY OCCI	URRED. (Enter nature o	f Injury in Part I or Part II of	Item 18.)
정 2Dc. TIME OF	INJURY Month, Day, Year 2	20d. INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, f	arm, 20f. (City or town)	(County) (State)
2Dc. TIME OF Hour a.		willie - Not while -	ory, street, office bldg.,	etc.)	
		t work at work	7	111	100
21. i certi	fy that (1) (this hospital) at	ttended the deceased from		96 bt, to 7 - 4	, 19 (1) (we) last
	eceased alive on 2	19 <u></u>	t death occurred at	M, from the causes a	nd on the date stated above.
22a. SIGNATU	. 0 //-	1-1:0	ATTENDING		22b. DATE SIGNED
sna	urue C. O.	orin feur M.I	D. PHYS.	MED. STAFF PHYS.)-3-67
22c. PHYSICI NAME (T	AN'S		22d. ADDRESS		
TOWNE (I	M.C. Porter	field	H	ampstead, Md.	
23a. BURIAL, CREP	MATION, 23b. DATE THEREO		Y OR CREMATORY	23d. LOCATION (City, tow	n or county) (State)
REMOVAL (So Burial		967 Wesley Ceme	tom	Carroll Co.	Md.
24. FUNERAL DIR		967 Wesley Ceme	25a. RE	C'D BY REGISTRAR 25b. REG	
Page 100 to 100	ine Funeral Hon	ne Hampstead, Md			(Charles Juage
	TATO I WHOLGE HOR	no manipoveau, Mu	• DATE		and Jungar

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b 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
	09424 CERTIFICATE OF DEATH	09424
Pond Ford	1. PLACE OF DEATH o. COUNTY CArroll MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution of the state of the	У
haurs affer n by the Tu s. Pages T hours affer	b. CITY OR TOWN (If outside corporate limits, write RURA write RURAL and give neorest town) RUFA - FINKS BURG d. NAME OF HOSPITAL OR INSTITUTION (If not in bospitol, give street oddress) d. STREET ADDRESS	30.4
nin 24 haur filled in by papers. P hin 72 hour	Route 2 3411 Ash Street	e. IS RESIDENCE ON A FARM? YES NO
ed within	3. NAME OF DECEASED (Type or print) WM Frank Middle Smith OF DEATH JULY	3. 1967
e executed with and campletely remare carban any eventual.	MARE White WIDOWED DIVORCED April 12, 1894 73 vis.	Manths Doys Hours Min.
icate be ex isician and please rem I, and in an	10b. USUAL OCCUPATION (Give kind of work dane during prost of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY I	12. CITIZEN OF WHAT COUNTRY'S
certificate b g physicion hen please noval, and i	13. FATHER'S NAME WM Smith MATILLA Williams	5
ne death cer attending p permit. The	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Ves, no, grunknown) (If yes give wor or dotes of service) 2/2-10-8137 MES. DORA-Smith-BA	timore, Md.
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after the retained by the haspital ar attending physician. SIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the a shauld be detached far use as the burial-transit permit. Then please remare carban papers. Pages ed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 72 hours after the state Dept.	18. CAUSE OF DEATH (Enter only one couse per line for (D)(b), ond (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO DUE TO	INJERVAL BETWEEN DINSET AND DEATH
iw required in physical physic	Conditions, if ony, which gave rise to immediate cause (a), stating the underlying couse lost. (b) DUE TO (c) Takeular arterioseleson	20 5 412.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital ar attending TO FUNERAL DIRECTOR: After this certificate has been a director, page 3 shauld be detached far use as the Ishauld be filed with the State Dept. of Health priar to be a shauld be filed with the State Dept.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)	19. WAS AUTOPSY PERFORMED? YES NO
rSician aspital certifica hed far t. of He	200. ACCIDENT WAS UNDERLYING 2005. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Part-II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
OR ATTENDING PHYSICIAL be retained by the haspital SIRECTOR: After this certifica te 3 shauld be detached fail ed with the State Dept. of He	20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED OF INJURY (Home, form, foctory, street office bidg., etc.) 20e. PLACE OF INJURY (Home, form, foctory, street office bidg., etc.)	(State)
TENDIN		, 196
OR AT OR AT DIRECTO	220. SIGNATURE M.D. ATTENDING MED. STAFF PHYS. STAFF PHYS. ON THE PHYS. O	22b. DATE SIGNED 7-3-67
TO HOSPITAL Page 4 may TO FUNERAL I director, pag	22c. PHYSICIAN'S DAGES GASTEN 22d. ABBRESS PERSTOWN	i, //
TO HOO Page direct	230. BURIAL PREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town BREMOVAL (Specify) 7-6-67 Old OAKLAND CEMERY SYKESU	Ile, Md.
VR A15 (4) 25M 1/67	Harry W. Haight Sykesvelle, W. J. DATES UL 7 1967 KG	istrary signature

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09425 requires that the deoth certificote be executed within 24 hours after, deoth 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY Maryland Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Cumberland the ottending physicion and completely filled in by sit permit. Then please remove carbon papers. llmos.ldv. Sykesville e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS rremotion, or removal, and in any event, within 72 h Springfield State Hospital 920 Maryland Ave. NO TX YES Middle NAME OF First Lost 4. DATE Doy Year DECEASED WILLIAM ROY SMITH DEATH (Type or print) 9. AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED Months birthdoy) Doys Hours X 11-10-1889 Male White WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? INDUSTRY Pennsylvania 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Morgan Smith Martha Cavandar 17. INFORMANT Address IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 215-36-9062 Records. Springfield State Hospital No 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the buriol-tronsit p ONSET AND DEATH AN CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic heart disease ears TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Page 4 may be retained by the hospital or attending physician. DUF TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse **TO FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CBS assoc. with senile brain disease, with psychotic reaction. WAS AUTOPSY PERFORMED? NO X Infected bedsores. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While of work ot work 21. I certify that (1) (this hospital) attended the deceased from 8-25-66 7-26-67, 19___, that (I) (we) lost M, from causes and on the date stated obove. 7-26-67 ond that death occurred of saw the deceased alive an_ 22b. DATE SIGNED 220. SIGNATURE MED. DIRECTOR **ATTENDING** X 7-26-67 M.D. PHYS. PHYS. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. Sykesville, Maryland D. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23b. DATE THEREOF 23o. BURIAL, CREMATION, REMOVAL (Specify) ARTEMAS. PA. FATRVIEW CEMETERY 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATUR FUNERAL DIRECTOR VR A15 (4)

A RESTORATION AND THE PARTIES. ,

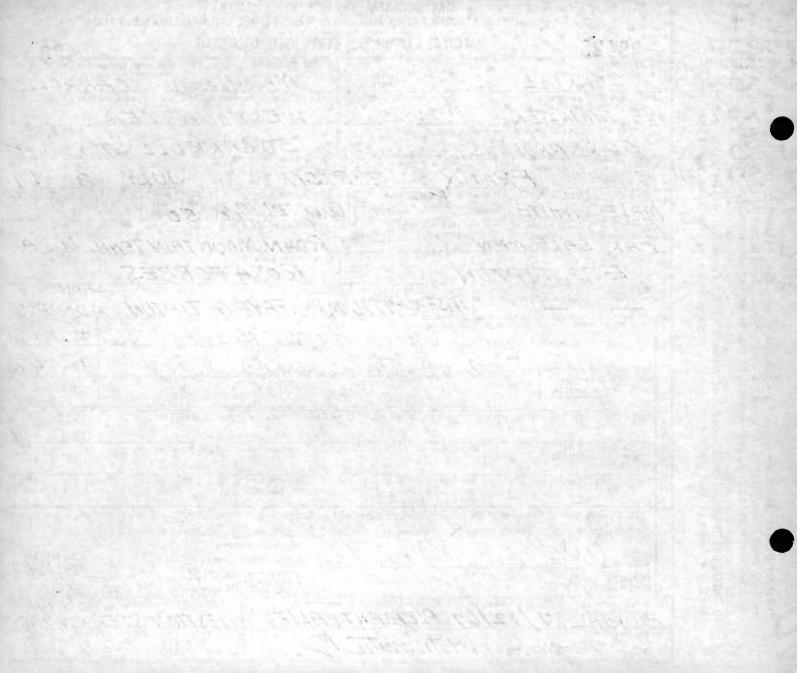
	7-24-67 ams Divisi	on of STATISTICAL	MA RESEAR	ARYLAND STATE D CH AND RECORDS, 3	DEPARTMENT OF H	EALTH EET, BALTIMORE, MA	RYLAND 2120	1
E	09426				CERTIFICATE C		0.5	426
T.	1. PLACE OF DEATH o. COUNTY Carro	011		MARYLAND	2. USUAL RESIDENCE (o. STATE Mary	Where deceosed lived, if in b.	stitution: Residence COUNTY	before odmission)
	b. CITY OR TOWN (If outside write RURAL and give respectively)		ם כ	LENCH OF STAY IN 16 6 yrs/6 mos	c. CITY OR TOWN (If or	utside carporate limits, writ	e RURAL ond give r	neorest tawn)
2	d. NAME OF HOSPITAL OR I	NSTITUTION (If not in h	ospitol, give	street oddress)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?
	Springfield		oital		?			YES NO
1	3. NAME OF DECEASED (Type or print)	First Charles	3	Middle NMN	SZYMANSKI	OF DEATH J		Doy Year 11: 19 67
	male wh	nite W	IARRIED [NEVER MARRIED DIVORCED	8. DATE OF BIRTH 7-8-29	9. AGE (In year lost birthdo	ors IF UNDER 1 Y by) Months I	VEAR IF UNDER 24 HRS. Doys Hours Min.
	10o. USUAL OCCUPATION (Give k during most of working life, eve Dependent	ind of work done n if retired)	10b. KIND INDUS	OF BUSINESS OR STRY	11. BIRTHPLACE (Stote	9	COUN	ZEN OF WHAT NTRY?
	13. FATHER'S NAME Joseph Szyme 15. WAS DECEASED EVER IN U.S. (Yes, no, or unknown) no	Anski ARMED FORCES? Jive wor or dotes of servi	16. SOC n		Anna Kor INFORMANT	well	Address	
No. of the last	18. CAUSE OF DEATH (E PART I. DEATH WAS I Conditions, if only, which rise to immediate coust stoting the underlying clost.	CAUSED BY: MMEDIATE CAUSE (o) DUE TO gove (b)	As	Phicia	LARYX, TO	echara Pha	rnyx	Minutes
	Mental De	Ciciency wi	thout	psychosis,	idiot level		in Astron	19. WAS AUTOPSY PERFORMED? YES NO
	20c. TIME OF INJURY Mo Hour o.m. p.m.	inth, Doy, Yeor	Occ 20d. INJUR While of work	urred while RY OCCURRED 20e. P Not While ot work	LACE OF INJURY (Home, form actory, street, office bldg., etc.	n 20f. (City or tow	n) (Count	iy) (Stote) roll
2	ACTUAL SIGNATURE EXAMINER'S	I took charge of the Notural country of the N	uses 🔀	Accident [], Su	M.D. ASSISTANT MED DEPUTY MEDICA	·	Inquiry, d monner	22. DATE SIGNED
X =	230. BURIAL, CREMATION,	23b. DATE THEREOF 7/17/67		23c. NAME OF CEMETERY O		23d. LOCATION (City of	r Town) (Co	ounty) Specific
2		chimunek Fu				D BY REGISTRAR 2SE	REGISTRAR'S SIGN	NATURE

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	1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAR	YLAND 21201
		09427 CERTIFICATE OF DEATH	09427
PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death e haspital or attending physician. his certificate has been signed by the attending physician and campletely filled in by the funeral stached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and Dept. af Health priar ta burial, crematian, ar removal, and in any event, within 72 haurs after death	1.	CANTOLL MARYLAND MARYLAND	OUNTY CARROLL
ted within 24 hours after pletely filled in by the f carbon papers. Pages art, within 72 haurs after	4	b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL ANALY OF HORDER OF MENULYMAN (If outside carporate limits, write RURAL AND	RURAL
illed ir illed ir no 24 h		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES \(\sum \) NO \(\sum \)
ed withi		OF TULY DEATH OF TULY DEATH TULY	onth Doy Year 1967
and cam remover	S.	M WIDOWED DIVORCED SEPT9-1930 36 yrs.	Months Doys Hours Min.
equires that the death certificate be execut physician. signed by the attending physician and carriburial-transit permit. Then please removiburial, crematian, ar removal, and in any evential, crematian, ar removal.	dur	USUAL OCCUPATION (Give kind of work done ng most of working life, even if retired) HOUSTRY FATHER'S NAME 11. BIRTHPLACE (County & Stote, or foreign country) WEST VIRGINIA 14. MOTHER'S MAIDEN NAME	12. CITIZEN OF WHAJ COUNTRY?
certific g phys Then p moval,		DORSEY TIGHE VIRGINIA GRUBB	
he death ce attending permit. The		WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Add (If yes give wor or dates of service) 232-32-9425 CHARLOTTE TIGHE U.S.	NION BRIDGE
hat the n. vy the c ansit po		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Order any Thruslesia	INTERVAL BETWEEN ONSET AND DEATH
The law requires that tather attending physician. has been signed by the se as the burial-transit the priar ta burial, cremana.		Conditions, if ony, which gove (b) (b)	sudden
the law red attending p has been si se as the b h priar ta bh		stoting the underlying couse DUE TO last. (c)	
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PHYSICIAN le haspital his certifical stached far Dept. af He	L CERTIFICATION	20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)	
the horring the post of the Dep	MEDICAL	20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19 20d. INJURY OCCURRED While of work of	(County) (Stote)
OR ATTENDING be retained by the MRECTOR: After the 3 should be d ed with the State		21. I certify that (I) (this hospital) attended the deceased fram 3/1/44, 19, to 4/7 sow the deceased alive an 7/47 19, and that death occurred at 2.34 M, from couse	s ond on the date stated obov
OR ATTENION DIRECTOR: A Shauld ed with the		220. SIGNATURE M.D. ATTENDING MED. DIRECTOR DIRECTOR PHYS.	22b. DATE SIGNED
Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. af Health priar ta		22c. PHYSICIAN'S NAME (Type) ME ROBERTSON 22d. ADDRESS Mul Wi	indown, md.
TO HOSPITAL Page 4 may TO FUNERAL director, pag	-	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City of LOCATION (Specify), TULY 9-1967 MT VIEW LINION BN	PIDGE MD
VR A15 (4) 20 M 1/66	24	FUNERAL DIRECTOR 2000. REC'D BY REGISTRAR 256. PEC'D BY REGISTRAR 256. PLANTED LINE STUDIES DATE UL 1 1967	REGISTRAR'S SIGNATURE

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The Park of the Pa	

	Division of STATISTIC		PARTMENT OF HEALTH 1 W. PRESTON STREET, BALTIMORE, MA	RYLAND 21201
FOR STATE	09428		CERTIFICATE OF DEATH	39/20
HEALTH DEAT.	1. PLACE OF DEATH	Α	2. USUAL RESIDENCE (Where deceosed lived, if in:	
京古岛	O. COUNTY CARROLL	MARYLAND	O. STATE MARYLAND.	CARROLL
ty delay is and 3 ta PM3. Page art ment of ther death	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If autside corparate limits, write	RURAL and give nearest tawn)
PM3 PM3 partm partm after	NESTIMINSTER	in hospital, give street address)	d. STREET ADDRESS	TER 06
th. If a ges 1, farm farm	50 CARRALL	in nospirol, give street oddress)	50 CARROL	e. IS RESIDENCE ON A FARM? YES NO
haurs after death. If any delay litem 18. Give Pages 1, 2, and 3 Office alang with farm PM3. Page 1 and 2 with the State Department.	3. NAME OF First	Middle		Month Doy Year
haurs after death tem 18. Give Page Office alang with and 2 with the Stat event within 75 pa	DECEASED (Type or print)	ANK TIP	PTON OF DEATH JL	124 8 1967
after 8. Giv alang alang with	S. SEX 6. COLOR OR RACE		B. DATE OF BIRTH 9. AGE (In yeo lost birthdo	rs IF UNDER 1 YEAR IF UNDER 24 HRS. y) Months Doys Hours Min.
haurs Item 18 Office and 2 v	MALE WHITE	WIDOWED DIVORCED D	Ma. 28, 19/6 50 Y	rs.
thaurs Item 18 Office Jand 2 v	10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 SIRTHPLACE (Stote or foreign country)	12. CITIZEN OF WHAT COUNTRY?
thin 24 ncil in I niner's pages I in any	13. FATHER'S NAME	·/V	14. MOTHER'S MAIDEN NAME	VENN. 45,74.
l within n pencil Examin File pag and in	E, D, TIPT	DN	ROSA FORB	ES .
ed with personal Example of the File I, and I, and II.	1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of s	16. SOCIAL SECURITY NO. 17.	INFORMANT	Address SAME
ecut ling edicc edicc ermi		42-36-11/61	MRS. FAGE G. TIPI	TON ADDRESS
shauld be executed to ward "pending" of the Chief Medical burial-transit permit.	1B. CAUSE OF DEATH (Enter only one cause PART I. DEATH WAS CAUSED BY:	10.10.501	2. + 1/00. XI	INTERVAL BETWEEN
Id by Chie	444 X IMMEDIATE CAUSE (o		esous read se	SKARO SOUNTER
wa wa the urial	Conditions, if ony, which gove)	Hyperteus	ios Addiahate	14-546
ate shauld 3 the ward 1d ta the C a burial-tr crematian,	rise to immediate couse (o), Stoting the underlying couse			
certifica , writing arwarde used as burial, c	last. (c)		
This certificate shauld be executed within 24 haurs after death. If a licate, writing the ward "pending" in pencil in Item 18. Give Pages 1, be farwarded to the Chief Medical Examiner's Office along with farm 1 be used as a burial-transit permit. File pages I and 2 with the State Dear to burial, cremation, ar remayal, and in any event within 70 bours	PART II. OTHER SIGNIFICANT CONDITIONS CON	ITRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c	19. WAS AUTOPSY PERFORMED? YES NO
4 0	200. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m.	20b. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Port I or Port II of item 18)
AL EXAMINER: execute the certifue. The Page 4 shauld for your files. Tong 8 should for your files. Tong 9 should files.	20c. TIME OF INJURY Month, Doy, Yeor Hour o.m.	20d. INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, form, 20f. (City or tow	n) (County) (Stote)
9 9 9 9	p.m. 19	ot work U	ory, street, office bldg., etc.)	
letral EXA size execute irectar. Page ained far yar iRECTOR: Pag designated a		of the remains described above, he		Inquiry, ond in my opinion
MEDICAL E	deoth resulted from: Natural	couses Accident , Suic	ide , Homicide , Undetermine	d manner
N P P P N	SIGNATURE Willes	1 to Dichi	CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
	EXAMINER'S	1	DEPUTY MEDICAL EXAMINER	A 7-18-67
	NAME (Type)	FOF 1 00 HAVE OF COLUMN	Add Steel Whole of source	esnusely 1
TO FI	230. BURIAL, CREMATION, 23b. DATE THERE	23c. NAME OF CEMETERY OR	CREMATORY: 23d. LOCATION (City of	MCTED OTHER
W	24. FUNERAL DIRECTOR	ADDRESS	2So. REC'D BY REGISTRAR 2SE	REGISTRAR'S AIGNATURE
VR A15ME (\$) 6M 1/66	& 2. myero, fr.	, wesmule,	DATE JUL 12 1967	Charles Judge

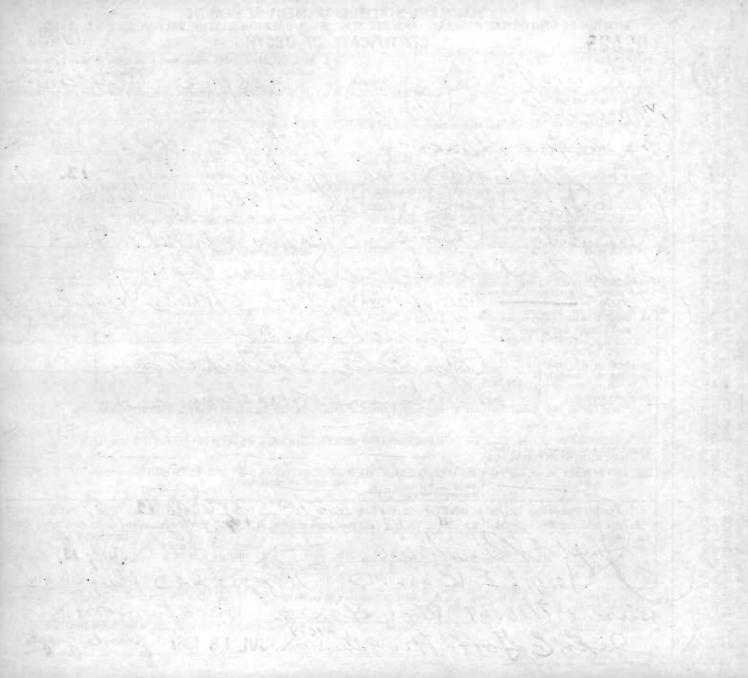


completely filled in by the funeral vye carbon papers. Pages 4 and 2 event, within 72 hours after teath.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND,

	09423 CERTIFICAT	TE OF DEATH	いっている
1	PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, If institution:	esidence before admission)
	a. COUNTY ATTO //	a. STATE b. COUNTY	201-1
-	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b	c. CITY OB TOWN/If outside corporate limits, write RURAL	and give nearest town)
	Write RURAL and give nearest town)		and give near est term)
1	MANGE HOOVER OF HOOVER OF HOOVER	Parken	13.4
1	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
	Xmy new Musinstime	Whiley Day you	YES NO NO
3	NAME/OF DEGEASED (Type or print) NAME/OF First Middle	Last 4. DATE Month OF DEATH	Day Year / 3 - 1967
5	SEX 6. COLOR OF RACE 7. MARRIED NEVER MARRIED	8 DATE OF BIRTH 1A ACE/ID years VIETINDER	10-/
-	Jenuly April WIDOWED DIVORCED DO	Luce 21, 1861 last birthday) Months	Days Hours Min.
	Da. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR uring most of working life, even if retired) NDUSTRY		ITIZEN OF WHAT
	Disquestante Jame	Baltines Sent Med	His A.
1	3 FATHER'S NAME	14 MOTHER'S MAIDEN NAME	
	J. VI Zhududound	Martha Barens	
	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	INFORMANT / Address	
49	Yes, no, or unkown) (If yes give war or dates of service)	2 1 .el. partio de	1.0.121
=	18. CAUSE OF DEATH (Enter only one cause per tine to (a), (b), and (c), 1	mes william + 11 ruce stay	Wacury M
1	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:		ONSET AND DEATH
	1921 IMMEDIATE CAUSE (a) Armel M	yochekilis	
	DUE TO O A	- () a () a m	
Т	Conditions, If any, which (b) Muselinke	and Casala clesion	
	gave rise to Immediate cause (a), stating the DUE TO		100
	underlying cause last. (c) / Turky	Demelien.	
NO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(2)	19. WAS AUTOPSY
PAT			PERFORMED?
	20a, ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCC	CURRED, (Enter nature of injury in Part I or Part II of Item 18	
CERTIFICATION	OR CONTRIBUTING CHOAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	TOTALES. (Enter nature of injury in tare 1 of fact 1 of item 10	-7
100			(04-1-)
MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, farm, 20f. (City or town) (Cou	inty) (State)
M	Hour a.m. While Not While at work at work		
	21. Certify that (I) (this hospital) attended the deceased from		
	saw the deceased alive on tally 19 67, and the	at death occurred at / M/ from the causes and on t	he date stated above.
	22a. SIGNATURE		ATE SIGNED
1	John of Luch we M	.D. ATTENDING MED. STAFF DIRECTOR PHYS. D	4 13, 1967
	22c. PHYSICIAN'S / I F R . C NO.	22d, ADDRESS	1,1
	109th E. Dush NO	JAMPSTEAD Max	yhore.
2	BURIAL, CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETER	RY OR CREMATORY 236 LOCATION (City, town or co	unty) (State)
	BING CH 7/16/67 Rine X	some barkton, or	md.
7	4. FUNERAL DIRECTOR ADDRESS	2 107 4 25a. REC'D BY REGISTRAR 25b. REGISTRAR	'S SIGNATURE
	Q. 6.18 H. H. Th. 1017	200 9 1111 1 8 1967 Milan	les Judges

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and condirector, page 3 should be detached for use as the burial-transit permit. Then please remove should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any ever VR A15 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09430 requires that the death certificate be executed within 24 haurs after death in by the funeral ers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admissiag) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside carparate limits, c. LENGTH OF STAY IN 16 limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS physician and completely killed S. Main Street NO V NAME OF Middle 4. DATE Manth Day DECEASED 22 Millad COM Harry SNEI (Type or print) 19 DEATH S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED AGE (In years remave birthdoy) Months Days Hours July 23, 1889 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) INDUSTRY COUNTRY? Retired Painter Carroll Co. Md. USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAMI ar remaval, Samuel Wisner Annie Blizzard 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war ar dates of service) 218-05-6222 Mrs. Treva R. Wisner Hampstead, Md. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise ta immediate cause (a), DUE TO stating the underlying cause as the priar tal has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) CFRTIFICATION TO HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the haspital or TO FUNERAL DIRECTOR: After this certificate NO far 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20c. TIME OF INJURY Manth. Day. Year 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) Nat While factory, street, office bldg., etc.) pe 21. I certify that (1) this haspital) attended the deceased framand that death occurred at 7:25 a M. Hom couses and an the date stoted above saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF DIRECTOR be filed 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) M. C. Porterfield. M. D. Hampstead Md. director, shauld 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (Caunty) (Stote) Burial July 25, 67 Hampstead Cemetery Hampstead, Md. 2Sa. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 Melizyles Tipton-Eline Funeral Home Hampstead, Md. DATE JUL 25 1967

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 09431 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Page and 3 ta of death. b. CITY OR TOWN (If outside carparate limits, delay Department of after death TOWN (If autside carparate limits, write RURAL and give nearest town) 2, o. PM3. write RURAL and give neorest town) Westminister d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE shauld be farwarded to the Chief Medical Examiner's Office along with farm ON A FARM? in Item 18. Give Pages e 4€ NO V Hospita 24 haurs after death. NAME OF Middle 4. DATE Day Year DECEASED 20 within (Type or print DEATH 19 S SEX 9: AGE (In veors IF UNDER 1 YFAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED pirthday) Months Days Hours Colored 11-16-1912 WIDOWED DIVOR CED and 2 event 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY any Laborer pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within = and 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) ar remaval. Dr. Donald Hughes 1B. CAUSE OF DEATH (Enter only one couse per line for INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) writing the ward This certificate should crematian, DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse 0 gp burial WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) the certificate, 0 pe 2Do. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING ☐ CAUSE OF DEATH. 20b DESCRIBE HOW INJURY OCCURRED. (Fater noture of injury in Just 1 or Part M agent, priar 20c. TIME OF INJURY Month, Doy, Year yaur Not While FUNERAL DIRECTOR: Page please execute its designated 21. I certify that I took charge of the remains described above, held on Autopsy [for Inspection [V Inquiry and in my opinian funeral director. Accident X death resulted fram: Natural causes Suicide Hamicide Undetermined manner may be retained CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER, Health ar **EXAMINER'S** Address (Steet, his/ town for county) NAME (Type) the 230. BURIAL CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 0 REMOVAL (Specify) Mt. Auburn Baltimore 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15ME (5) Milanes Charles R. Law. 802 Madison 25 196 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

by closed of and President and the state of the second
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) anchester d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 12FN man YES NO ely NAME OF Middle DATE Month Day Year DECEASED (Type or print) DEATH 5. SEX 6. COLOR OR RACE AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS DATA OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Days and Nov. WIDOWED | DIVORCED [10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) duting most of working life, even If retired) COUNTRY? clarke USA-13. FATHER'S NAME MOTHER'S MAIDEN NAME 18. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address OL (Yos, no, or unkown) | (If yes give war or dates of service) transit perm cremation, c 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN PHYSICIAN: The law requires that the the hospital or attending physician. been signed by the burial-transit or to burial, crem ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last, (c) 38 O PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY certificate h hed for use it, of Health p PERFORMED? CERTIFICATI NO E 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) etached for Dept. of I 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) det factory, street, office bldg., etc.) Not While at work at work OR ATTENOIN
be retained t o hould h the 21. I certify that (I) (this hospital) attended the deceased from age 3 should iled with the and that death occurred at 3.30 M. from the causes and on the date stated above. saw the deceased alive on DATE SIGNED 22a. SIGNATURE MED. DIRECTOR STAFF director, page should be filed PHYS. 4 may FUNERAL PHYSICIAN'S ADDRESS NAME (Type) 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Snydersburg Carroll Co. Snydersburg Cem. FUNERAL DIRECTOR REC'D BY REGISTRAR I Tipton - Eline Funeral Home Hampstead Md, VR A15 (4) 20M 1/65

death certificate be executed within

tool of your fallen

TIBERT CHEROLUS TIBERT UNION MILLS INC. " NESTMUNSTER PIEMDEN WEN CONSULHOME 180 W MAJN ST HARRY MILTON YOUNG LULY 29 67 PUE 30/887 79 DIATE NHITE KETHEED FRANCE ALBO MICKET ENGLISHE CARPROLL TO ARE MY BE JACOB DANKL YOUNG LOURS FORMULE 216-22-8248A ROUPH MYDUNG WESTMINGTHE NO Story Property and Sec. BURGAL 8/1/67 KRIDERS CEMETERY RUPAL WESTERMITTER The property profined to me will be the second

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: Rasidanca before admission)
CARRALL MARYLAND	a, STATE b. COUNTY
b. CITY OR TOWN (if outside corporata limits, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Write RURAL and give nearest lown) ININ PROPERTY DIPLOMENTAL	WASHINGTON DC 117
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS n. IS RESIDENCE
BROOKFIELD MANOR NURSING HOME	2500 WISCONSIN AVE N.W. YES NO NO
3. NAME OF First Middle Middle	Lasi 4. DATE Month Day Year
(Type or print) VIOLET FRANCES YOU	
S. SEX 6. COLOR OR RACE 7, MARRIED NEVER MARRIED 8	DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
WIDOWED DIVORCED	TILLY 7-1883 84 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTR	Y 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
dona during most of working life, avan if retired) HOUSEKFEPER OWN HOME	MISSAURI USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DR - DAVIS	ELLEN BUTLER
	INFORMANT Address
(Yes, no, or unkown) (Ifyes give were released service) 1117-31-4868 K	E YOUNKIN FREDERICK MD
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]	INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:	Les clerosis Gens
MANUAL CAUSE (6)	1030 4463/3
4500 DUE TO	
Conditions, if any, which gave rise to immediate cause (b)	
(a), stating the underlying DUE TO	
cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
E C	YES NO D
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO 208. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURED (IF EITHER, NOTIFY MEDICAL EXAMINER)	. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, farm, 1 20f. (City or town) (County) (Stata)
	ory, streat, office bldg., atc.)
21. I certify that (I) (this hospitel) attended the deceased from	2/11 (c7, 19, 10. 7//3 (c7, 19, that (I) (we) last
saw the deceased alive on 7/13 67 19 end that	death occured a 3/2M, from the causes and on the dete stated above.
222 STGNATURE	1 23b. DATE
(Astanicato	D. ATTENDING MED. STAFF PHYS. TILL TILL TO THE STAFF
22c. PHYSIGHAN'S	22d. ADDRESS
NAME (Type) J H CARICOFE	UNION BRIDGE MA
23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY 23d, LOCATION (City, town or county) (State)
REMOVAL (Spacify) 7/14/14 NACHINITAN	NATIONAL SUITLAND MD
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	258. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE
NO The Flat of land the	PATE JUL 17 1967 yellarlas Jusque
NN Market some your Drie	TO THE TOTAL

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #23a,b,c & CERTIFICATE OF DEATH 09435 09435 ve carbon papers. Pages Land évent, within 72 hours affer death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY Barroll b. COUNTY Maryland MARYLAND in by the Pages be executed within 24 hours after c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. write RURAL and give nearest town)
Rural--Sykesville 8m. 10d. Baltimore 25y. e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS filled 1506 N. Collington Avenue Springfield State Hospital NO DE attending physician and campletely foremit. Then please remove carbon NAME OF Middle 4. DATE Month Year DECEASED (Type or print) 1967 Ziegler 2 Mary DEATH 9. AGE (In years IF UNDER YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED **NEVER MARRIED** 76 ost birthdoy) Manths Days Hours 1/6/91 female white WIDOWED DIVORCED and in any 11. BIRTHPLACE (County & Stote, or foreign country) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done COUNTRY? INDUSTRY USA Pennsylvania requires that the death certificate 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME crematian, or remaval, Ludwig Lindemann Mary Schaefer 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. permit. (Yes, na, ar unknown) ((If yes give wor or dates of service) 220-54-6253-T Springfield Hospital records, Sykesville INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Congestive heart failure IMMEDIATE CAUSE (o) signed by Page 4 may be retained by the hospital ar attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Chronic hypochromic anemia Canditions, if any, which gove years rise to immediate couse (o), DUE TO stating the underlying cause as the 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Schizophrenic reaction, catatonic type. NO X 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (County) factory, street, affice bldg., etc.) Not While of work ot wark _____, 19**___**___, ta_ _, 1967 , that \$ (we) last 21. I certify that (this haspital) attended the deceased from. 10/22/ 7/2/ 7/2/ 167 and that death occurred at 12:45R. Hom causes and an the date stated above. saw the deceased alive on_ 22b. DATE SIGNED 220. SIGNATURE STAFF PHYS. 7/2/67 K -M.D. DIRECTOR be filled Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S N. Buyukunsal, M. D. NAME (Type) Sykesville. Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (Stote) 23a: BURIAL, CREMATION, REMOVAL (Specify) Sykesville Carrl Md. Freedom Cemeterv 250. REC'D BY REGISTRAR 19 **ADDRESS** 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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